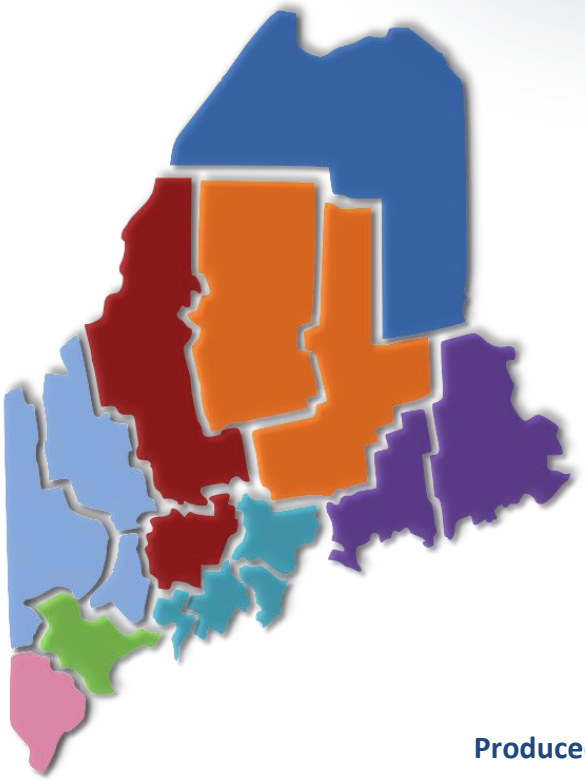
Substance Abuse Trends in Maine

Epidemiological Profile 2015

Aroostook District



Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Produced for Maine Department of Health and Human Services
Office of Substance Abuse and Mental Health Services
***by* Hornby Zeller Associates, Inc.**
October 2015

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Aroostook District

THIS REPORT IS PRODUCED FOR
THE MAINE OFFICE OF SUBSTANCE ABUSE
COMMUNITY EPIDEMIOLOGY SURVEILLANCE NETWORK
WITH SUPPORT FROM THE PARNTERSHIPS FOR SUCCESS GRANT THROUGH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION

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Introduction

Overview of Aroostook Public Health District

Aroostook Public Health District has a population of 69,447 people, representing approximately 5.2 percent of Maine's total population in 2014. There are 10.8 people per square mile, making it the most rural public health district in Maine. The State of Maine is considered an "aging" state, with 18.3 percent of the population being 65 years old and over, a higher rate than the overall US population (14%). In Aroostook Public Health District, 21.3 percent of the population was 65 years old or older in 2013. Approximately 95 percent of Aroostook's population is Caucasian, followed by American Indian and Alaska Native (1.9%), Hispanic (1.1%), and Black or African American (0.8%). With a median income of $37,855 (lowest public health district in the state), approximately 16 percent of the population lives below the poverty level. In sum, Aroostook tends to be older, poorer, and more rural compared to the rest of the state.

It is within the context of these demographic characteristics that substance abuse in Aroostook Public Health District (PHD) must be examined.

Purpose of this Report

This report takes into account the primary objectives of the Office of Substance Abuse and Mental Health Services (SAMHS): to identify substance abuse patterns in defined geographical areas, establish substance abuse trends, detect emerging substances, and provide information for policy development and program planning. It also highlights all the prevention priorities identified in the SAMHS strategic plan: underage drinking, high-risk drinking, misuse of prescription drugs, and marijuana use. Finally, the report monitors many of the factors that contribute to substance use, such as access and perceptions of harm, as well as the common negative consequences such as crime, car crashes and overdose deaths.

This report includes data available through May 2015. Older and unchanged data are included when more recent data were not available. Five major types of indicators are included: self-reported substance consumption, consequences of substance use, factors contributing to substance use, indicators about mental health and substance abuse, and treatment admissions.

The most recent data available for the Behavioral Risk Factor Surveillance System (BRFSS) are from 2013. Due to methodological changes in weighting and sampling, **2011 BRFSS data cannot be trended with previous BRFSS years.** In addition, please note that **data results from the 2013 Maine Integrated Youth Health Survey are not available for the Downeast Public Health District due to an insufficient sample size.**

Previous reports are available at the www.maineosa.org website. For additional data and resources please visit the Maine State Epidemiological Outcomes Workgroup (SEOW) data dashboard at www.maineseow.com.

Consumption of Substances

Consuming harmful substances can have detrimental effects on an individual's well-being, including increased risks of morbidity, addiction and mortality, and has a harmful effect on society as a whole including increased motor vehicle accidents and crime. However, it is the manner and frequency with which people drink, smoke and use drugs that are often linked to particular substance-related consequences. To understand fully the magnitude of substance use consequences, it is important to first understand the prevalence of substance use consumption, itself. Consumption includes overall use of substances, acute or heavy consumption and consumption by high risk groups (e.g., youth, college students, pregnant women).

As demonstrated by the indicators below, alcohol remains the substance most often used by Aroostook residents across the lifespan. In particular, high-risk drinking among the youth and younger adults continues to be a concern although it appears that youth in Aroostook are somewhat less likely to engage in high-risk drinking compared to the rest of the state. Tobacco use, particularly smoking cigarettes, appears to be higher among Aroostook's population when compared to the rest of the state. Prescription drugs and marijuana are the two most commonly used drugs in Maine and Aroostook is no different, although the rates of use tend to be somewhat lower compared to other regions.

Alcohol

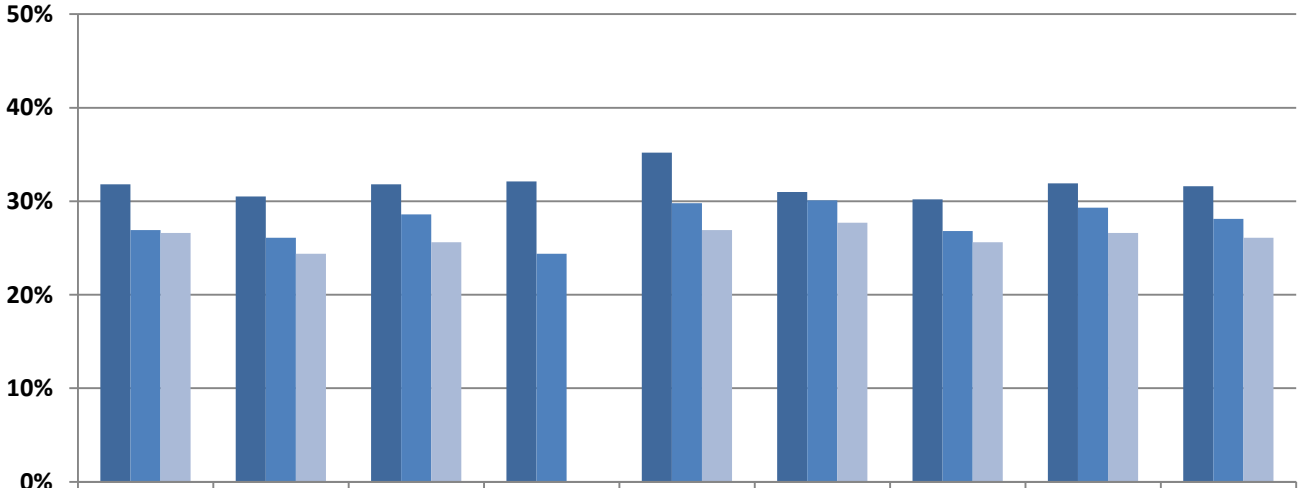
Indicator Description: ALCOHOL USE AMONG YOUTH. This measure shows the percentage of Maine high school students who reported having had one or more alcoholic drinks within 30 days prior to the survey.

Why Indicator is Important: Alcohol is the most often used substance among youth in Maine. In addition to the risks alcohol consumption carries for adults, developing adolescent brains are especially susceptible to the health risks of alcohol consumption. Adolescents who consume alcohol are more likely to have poor grades and be at risk for experiencing social problems, depression, suicidal thoughts, assault, and violence.

Data Source(s): MIYHS, 2009-2013

Summary: In Aroostook, the percentage of students who reported drinking in the past 30 days fell from 32 percent in 2009 to 27 percent in 2013, as compared to the percentage statewide, which decreased from 32 percent in 2009 to 26 percent in 2013.

Figure 1. Percent of high school students by Public Health District who had at least one drink of alcohol during past 30 days: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	32%	31%	32%	32%	35%	31%	30%	32%	32%
2011	27%	26%	29%	24%	30%	30%	27%	29%	28%
2013	27%	24%	26%		27%	28%	26%	27%	26%

Source: MIYHS

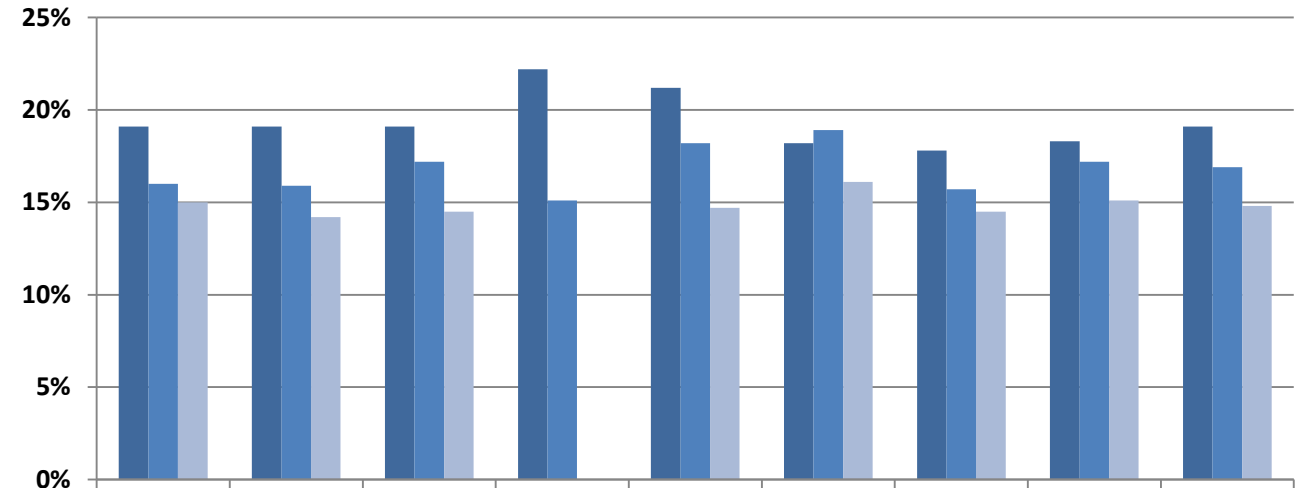
Indicator Description: HIGH-RISK ALCOHOL USE AMONG YOUTH. This indicator presents the percentage of Maine high school students who reported having had five or more alcoholic drinks in a row in one sitting at least once during the 30 days prior to the survey.

Why Indicator is Important: Youth are more likely than adults to engage in high-risk drinking when they consume alcohol. High-risk alcohol use contributes to violence and motor vehicle crashes and can result in negative health consequences for the consumer, including injuries and chronic liver disease. Youth who engage in high-risk drinking also are more likely to use drugs and engage in risky and antisocial behavior.

Data Source(s): MIYHS, 2009-2013

Summary: From 2009 to 2013, the percentage of high school students in Aroostook who reported having consumed five or more alcoholic beverages in one sitting during the past 30 days decreased from 19 percent to 15 percent. This is on par with the statewide average (15%).

Figure 2. Percent of high school students by Public Health District who had at least five drinks in a row during past 30 days: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	19%	19%	19%	22%	21%	18%	18%	18%	19%
2011	16%	16%	17%	15%	18%	19%	16%	17%	17%
2013	15%	14%	15%		15%	16%	15%	15%	15%

Source: MIYHS

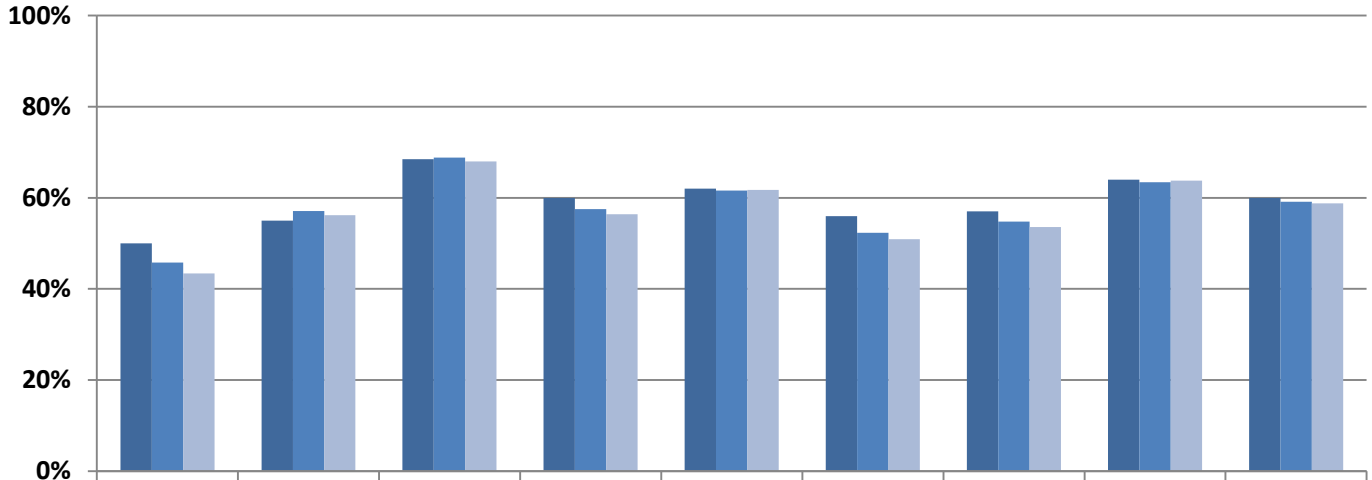
Indicator Description: ALCOHOL USE AMONG ADULTS. This indicator portrays the percentage of adults who reported having consumed one or more alcoholic drinks on one or more days within the past 30 days.

Why Indicator is Important: Alcohol is the most often used substance in Maine adults. Excessive and high-risk alcohol use may contribute to violence and result in many negative health consequences for the consumer. Moderate drinking can also have negative health effects and lead to such consequences as alcohol-related motor vehicle crashes and increased injuries. Current alcohol use in pregnant women is also linked to low birth weight babies, sudden infant death, and other developmental delays in children.

Data Source(s): BRFSS, 2011-2013.

Summary: The percentage of adults in Aroostook who consumed at least one alcoholic beverage within the past 30 days decreased from 2011 (50%) to 2013 (43%). This was 16 percentage points lower than the statewide average and the lowest rate among public health districts.

Figure 3. Percent of adults by Public Health District who reported drinking during past 30 days: 2011-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2011	50%	55%	69%	60%	62%	56%	57%	64%	60%
2012	46%	57%	69%	58%	62%	52%	55%	63%	59%
2013	43%	56%	68%	56%	62%	51%	54%	64%	59%

Source: BRFSS

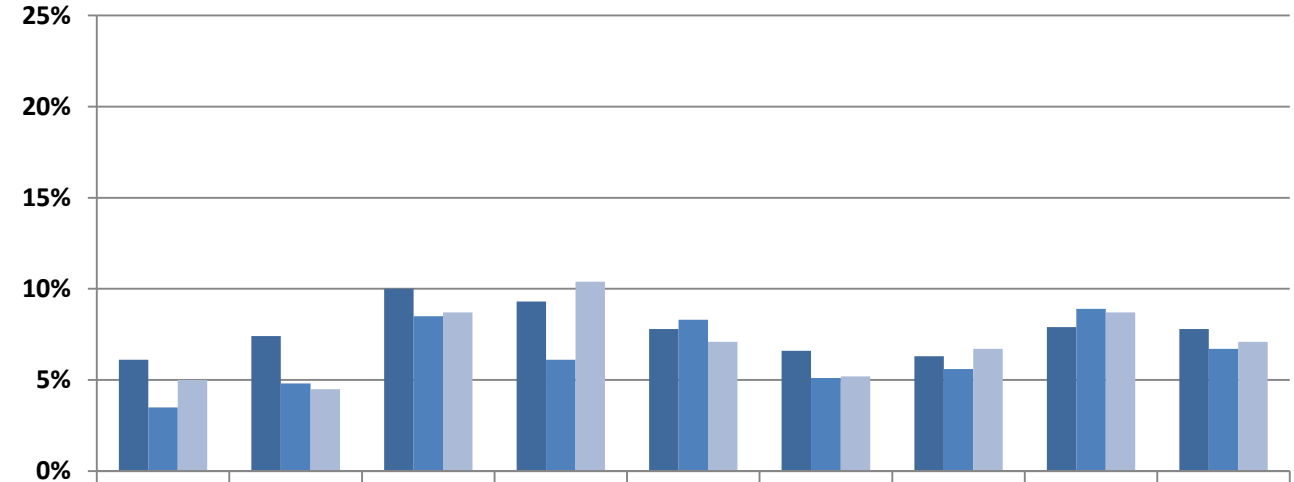
Indicator Description: AT RISK FROM HEAVY ALCOHOL USE. This indicator examines the percentage of Maine residents who are at risk from heavy drinking in the past month. Heavy drinking is defined as two drinks per day for a man or one drink per day for a woman.

Why Indicator is Important: Heavy drinking increases the risk for many health and social related consequences. People who consume alcohol heavily are at increased risk for a variety of negative health consequences, including alcohol abuse and dependence, liver disease, certain cancers, pancreatitis, heart disease, and death. It has also been found that the more heavily a person drinks the greater the potential for problems at home, work, and with friends.[1]

Data Source(s): BRFSS, 2011-2013.

Summary: The percentage of adults in Aroostook at risk from heavy alcohol use (1-2 drinks per day) decreased slightly from 2011 (6%) to 2013 (5%). This rate was slightly lower than the statewide average (7%) and the lowest among the public health districts.

Figure 4. Percent of adults by Public Health District who reported heavy drinking during past 30 days: 2011-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2011	6%	7%	10%	9%	8%	7%	6%	8%	8%
2012	4%	5%	9%	6%	8%	5%	6%	9%	7%
2013	5%	5%	9%	10%	7%	5%	7%	9%	7%

Source: BRFSS

[1] Citation from Alcoholscreening.org, a service of Join Together and the Boston University School of Public Health. Retrieved from http://www.alcoholscreening.org/Learn-More.aspx?topicID=8&articleID=26 on 7/11/2014.

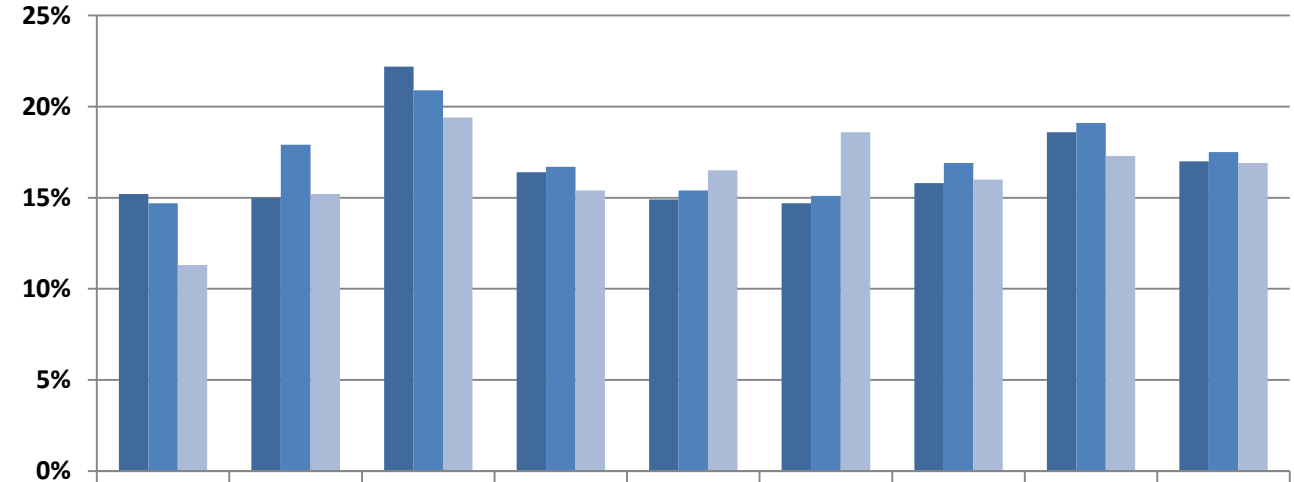
Indicator Description: HIGH-RISK ALCOHOL USE AMONG ADULTS. This indicator reflects the percentage of adults who reported engaging in high-risk "binge" drinking within the past 30 days. This is defined as five or more drinks in one sitting for a male and four or more drinks in one sitting for a female.

Why Indicator is Important: Binge drinking is considered to be a type of high-risk drinking, meaning it increases the risk for many health- and social-related consequences. It has been linked to injury (such as falls, fights, and suicides), violence, crime rates, motor vehicle crashes stroke, chronic liver disease, addiction, and some types of cancer.

Data Source(s): BRFSS, 2011-2013.

Summary: The rate of binge drinking during the past 30 days among adults in Aroostook decreased from 15 percent in 2011 to 11 percent in 2013.This was six percentage points lower than the statewide average (17%) and the lowest rate of the public health districts.

Figure 5. Percent of adults by Public Health District who reported binge drinking during past 30 days: 2011-2013

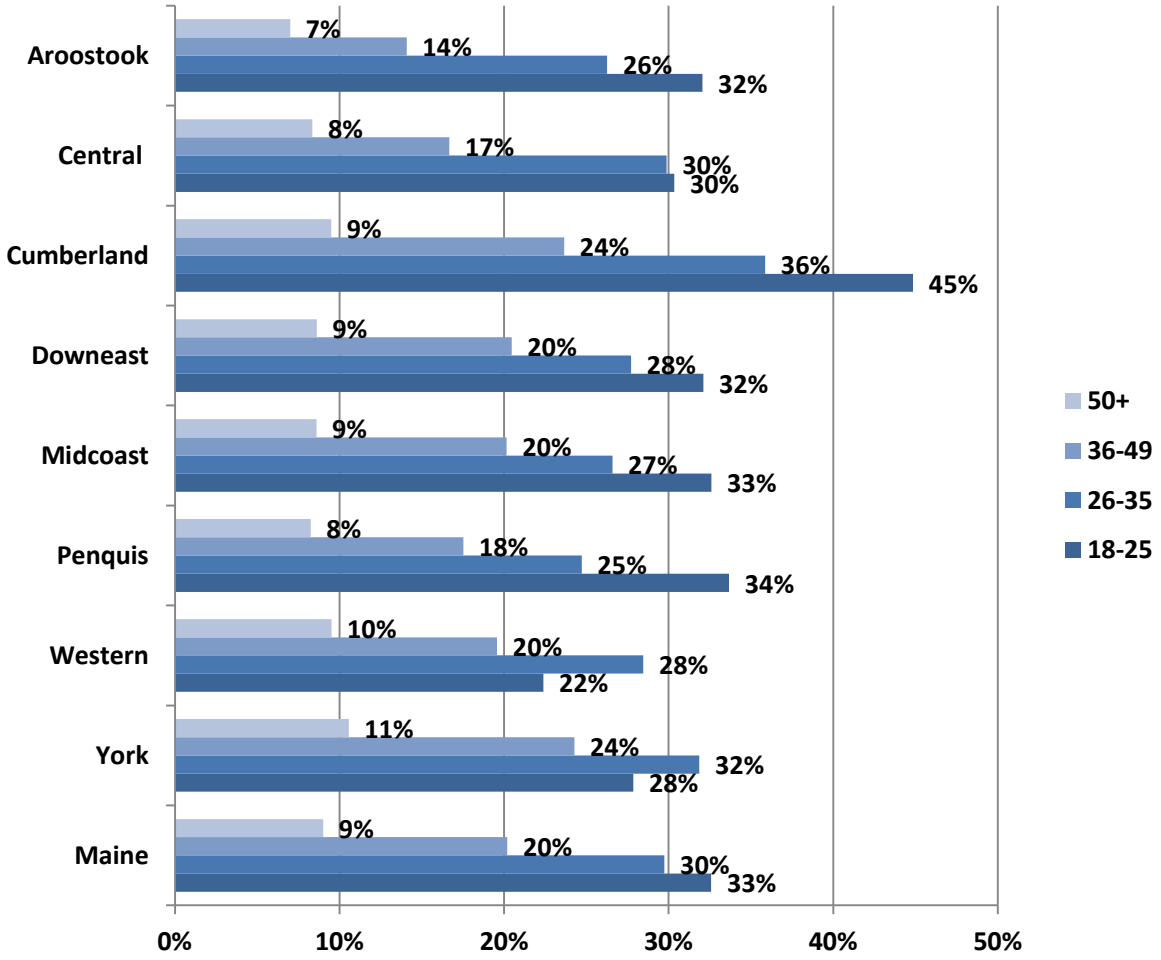


	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2011	15%	15%	22%	16%	15%	15%	16%	19%	17%
2012	15%	18%	21%	17%	15%	15%	17%	19%	18%
2013	11%	15%	19%	15%	17%	19%	16%	17%	17%

Source: BRFSS

Summary: Looking across all years of available data, the highest rate of binge drinking in Aroostook is observed among the 18 to 25 year old population at 32 percent. Those between the ages of 26 and 35 years old had the second highest binge drinking rate in Aroostook at 26 percent, followed by 36 to 49 year olds (14%), and residents age 50 and older (7%).

Figure 6. Percent of adults by Public Health District who reported binge drinking in past 30 days by age group: 2011-13



Source: BRFSS

Tobacco

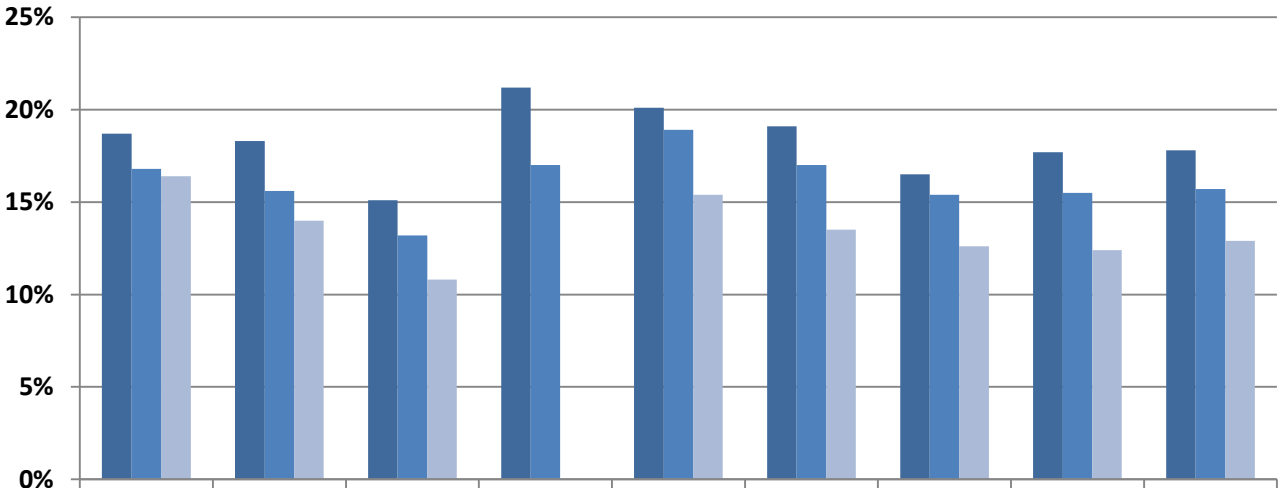
Indicator Description: SMOKING AMONG YOUTH. This indicator illustrates the percentage of Maine high school students who reported smoking a cigarette on at least one occasion within 30 days prior to the survey.

Why Indicator is Important: Use of tobacco is associated with a greater risk of negative health outcomes, including cancer, cardiovascular, and chronic respiratory diseases, as well as death.

Data Source(s): MIYHS, 2009-2013.

Summary: From 2009 to 2013 the percentage of high school students in Aroostook who reported having smoked one or more cigarettes in the past 30 days decreased from 19 percent to 16 percent. In 2013, this was the highest rate among public health districts and three percentage points higher than the state average (13%).

Figure 7. Percent of high school students by Public Health District who reported smoking one or more cigarettes during past 30 days: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	19%	18%	15%	21%	20%	19%	17%	18%	18%
2011	17%	16%	13%	17%	19%	17%	15%	16%	16%
2013	16%	14%	11%		15%	14%	13%	12%	13%

Source: MIYHS

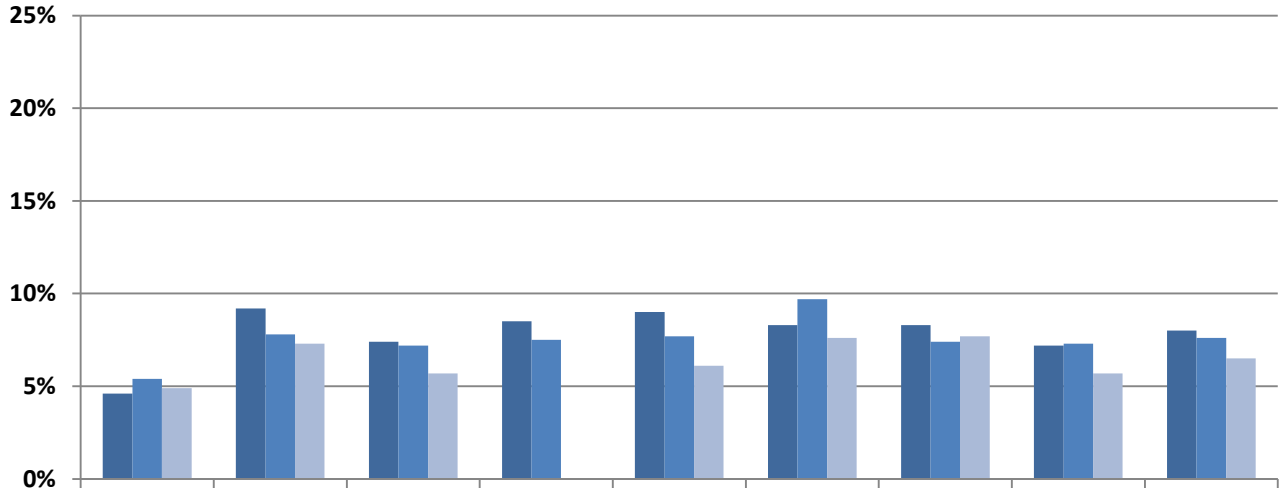
Indicator Description: SMOKELESS TOBACCO AMONG YOUTH. This indicator illustrates the percentage of Maine high school students who reported using smokeless tobacco on at least one occasion within 30 days prior to the survey.

Why Indicator is Important: Use of tobacco is associated with a greater risk of negative health outcomes, including cancer, cardiovascular, and chronic respiratory diseases, as well as death.

Data Source(s): MIYHS, 2009-2013.

Summary: The percent of high school students in Aroostook who have used smokeless tobacco in the past 30 days remained steady at five percent from 2009 to 2013. This is lowest among the public health districts and two points lower than the statewide average (7%).

Figure 8. Percent of high school students by Public Health District who used smokeless tobacco in the past 30 days: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	5%	9%	7%	9%	9%	8%	8%	7%	8%
2011	5%	8%	7%	8%	8%	10%	7%	7%	8%
2013	5%	7%	6%		6%	8%	8%	6%	7%

Source: MIYHS

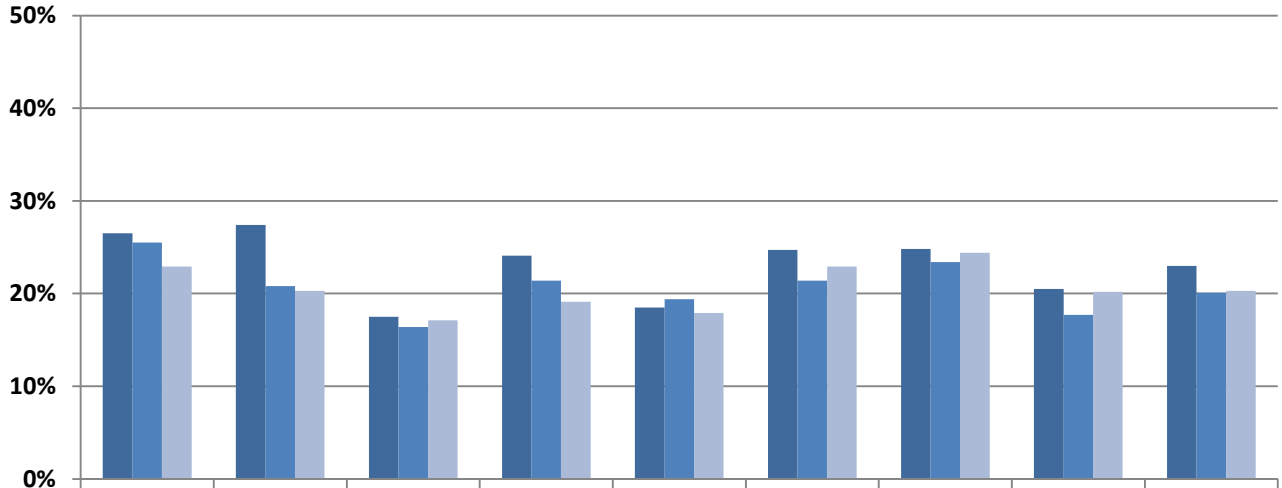
Indicator Description: SMOKING AMONG ADULTS. This indicator illustrates the percentage of Maine adults who reported using cigarettes on at least one occasion within 30 days prior to the survey.

Why Indicator is Important: Smoking is associated with a greater risk of negative health outcomes, including cancer, cardiovascular and chronic respiratory diseases, as well as death.

Data Source(s): BRFSS, 2011-2013.

Summary: In 2013, about one quarter (23%) of adults in Aroostook indicated they had smoked a cigarette in the past 30 days; this was among the highest rates among public health districts and three percentage points higher than the statewide average (20%).

Figure 9. Percent of adults by Public Health District who reported smoking a cigarette in the past 30 days: 2011-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2011	27%	27%	18%	24%	19%	25%	25%	21%	23%
2012	26%	21%	16%	21%	19%	21%	23%	18%	20%
2013	23%	20%	17%	19%	18%	23%	24%	20%	20%

Source: BRFSS

Prescription Drugs

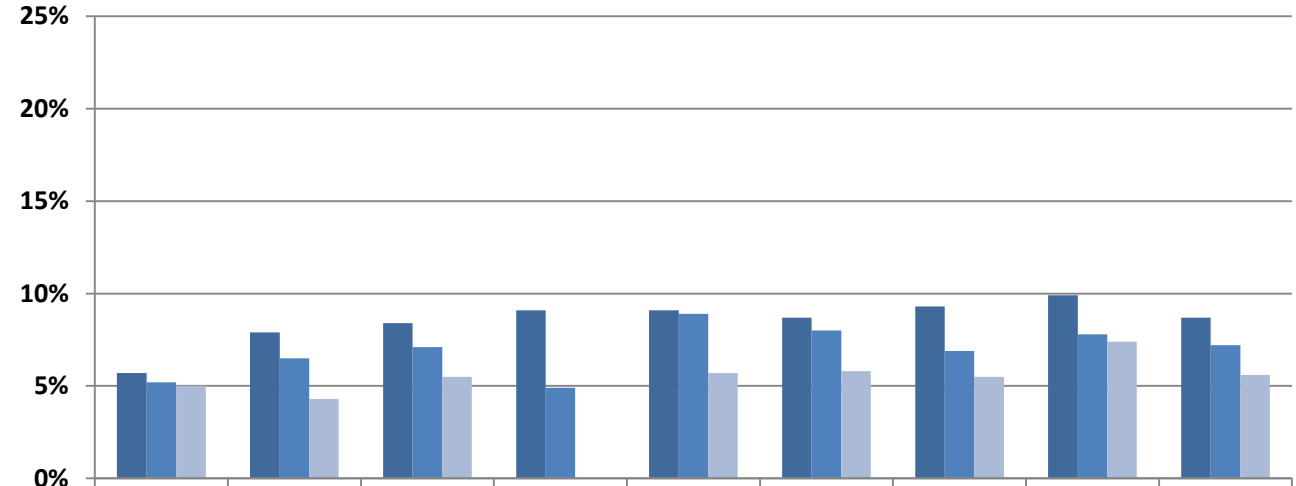
Indicator Description: MISUSE OF PRESCRIPTION DRUGS AMONG YOUTH. This indicator presents the percentage of Maine high school students who reported using prescription drugs that were not prescribed to them by a doctor within 30 days prior to the survey.

Why Indicator is Important: Some people are using available prescription drugs, including stimulants and opiates, instead of illegal drugs to get high. Abuse of prescription drugs may lead to consequences such as unintentional poisonings or overdose, automobile crashes, addiction, and increased crime.

Data Source(s): MIYHS, 2009-2013.

Summary: In 2013, five percent of high school students in Aroostook reported having taken prescription drugs not prescribed to them by a doctor one or more times in the past 30 days, a slight decrease since 2009.

Figure 10. Percent of high school students by Public Health District who have taken prescription drugs not prescribed to them by a doctor (past 30 days): 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	6%	8%	8%	9%	9%	9%	9%	10%	9%
2011	5%	7%	7%	5%	9%	8%	7%	8%	7%
2013	5%	4%	6%		6%	6%	6%	7%	6%

Source: MIYHS

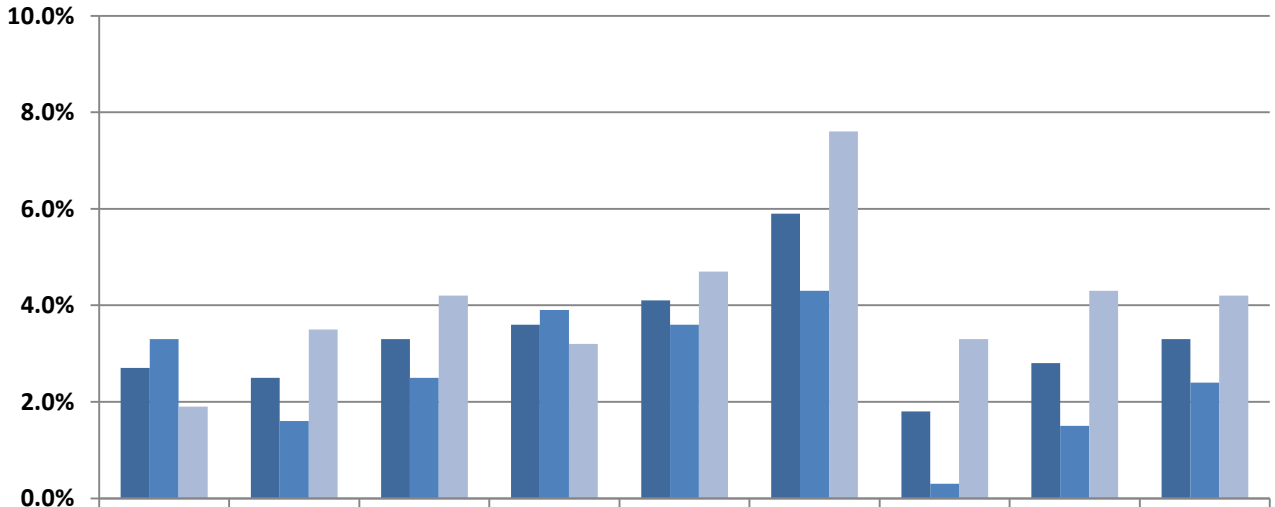
Indicator Description: MISUSE OF PRESCRIPTION DRUGS AMONG ADULTS. This measure reflects the percentage of adults in Maine who reported using prescription drugs not prescribed to them by a doctor, or using them in a way other than the one prescribed, at least once in their lifetime. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

Why Indicator is Important: Some Mainers misuse available prescription drugs (including stimulants and opiates) instead of illegal drugs to get high. Abuse of prescription drugs may lead to consequences such as unintentional poisonings, overdose, dependence and increased crime.

Data Source(s): BRFSS, 2011-13

Summary: During 2011-13 (combined years), about three percent (2.7%) of adults in Aroostook reported to have misused prescription drugs in their lifetime. This differed little from the statewide average (3.3%). Females in Aroostook were more likely to report having misused prescription drugs in their lifetime than males (3.3% compared to 1.9%).

Figure 11. Misuse of prescription drugs among Maine residents (18 and older) in their lifetime, by gender and public health district: 2011-13



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
Total	2.7%	2.5%	3.3%	3.6%	4.1%	5.9%	1.8%	2.8%	3.3%
Female	3.3%	1.6%	2.5%	3.9%	3.6%	4.3%	0.3%	1.5%	2.4%
Male	1.9%	3.5%	4.2%	3.2%	4.7%	7.6%	3.3%	4.3%	4.2%

Source: BRFSS

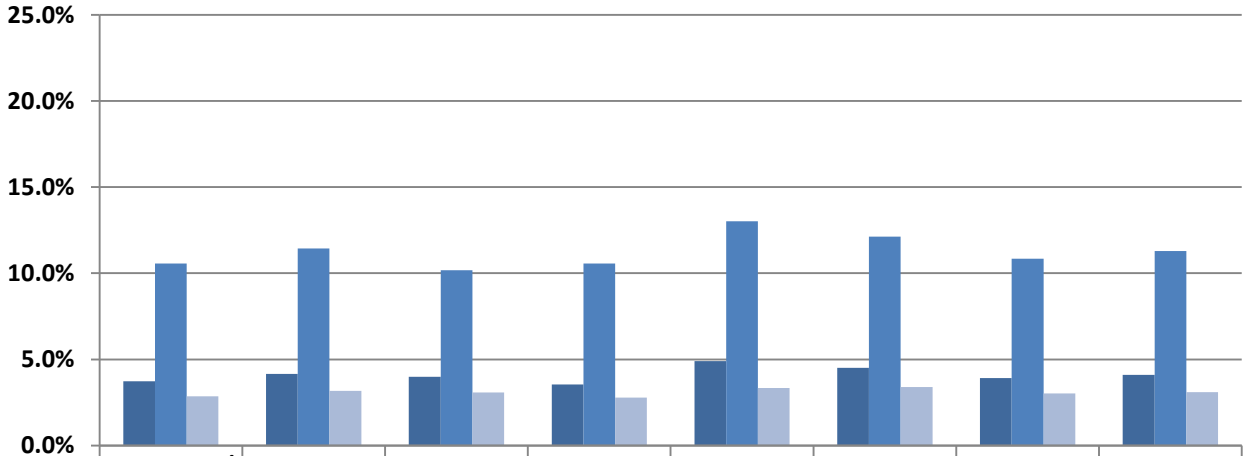
Indicator Description: NONMEDICAL USE OF PRESCRIPTION PAIN RELIEVERS AMONG MAINERS AGE 18 AND OLDER. This measure reflects the percentage of adults who reported using prescription pain relievers in the past year, for reasons other than their intended purpose. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

Why Indicator is Important: Mainers are increasingly using available prescription drugs, particularly pain relievers, instead of illegal drugs to get high. Abuse of prescription drugs may lead to consequences such as unintentional poisonings, overdose, dependence and increased crime.

Data Source(s): NSDUH, 2010-12.

Summary: In 2010-12, 10.6 percent of 18 to 25 year olds in Aroostook/Downeast reported non-medical use of prescription pain relievers during the past year, compared to 2.9 percent among those who were 26 and older.

Figure 12. Percent of population 18 years old or older who used prescription pain relievers in past year for nonmedical use, by Public Health District: 2010-12

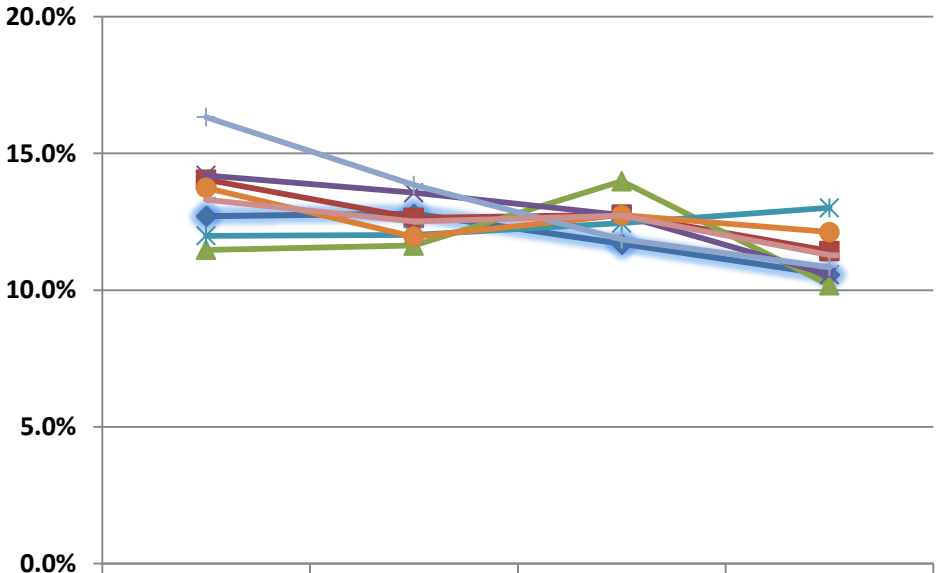


	Aroostook/ Downeast	Central	Cumber.	Midcoast	Penquis	Western	York	Maine
18+	3.7%	4.2%	4.0%	3.5%	4.9%	4.5%	3.9%	4.1%
18 to 25	10.6%	11.4%	10.2%	10.6%	13.0%	12.1%	10.8%	11.3%
26+	2.9%	3.2%	3.1%	2.8%	3.3%	3.4%	3.0%	3.1%

Source: NSDUH

Summary: Past year use of non-medical pain relievers among 18 to 25 year olds in Aroostook/Downeast decreased by two percentage points from 2004-06 (12.7%) to 2010-12 (10.6%). This was on par with rates at the state level.

Figure 13. Percent of 18 to 25 year olds who used prescription pain relievers in past year for nonmedical use, by Public Health District: 2004-06 to 2010-12



	2004-06	2006-08	2008-10	2010-12
Aroostook/Downeast	12.7%	12.8%	11.7%	10.6%
Central	14.0%	12.6%	12.8%	11.4%
Cumberland	11.5%	11.6%	14.0%	10.2%
Midcoast	14.2%	13.6%	12.8%	10.6%
Penquis	12.0%	12.0%	12.5%	13.0%
Western	13.7%	12.0%	12.7%	12.1%
York	16.3%	13.8%	11.9%	10.8%
Maine	13.3%	12.5%	12.7%	11.3%

Source: NSDUH

Other Illegal Drugs

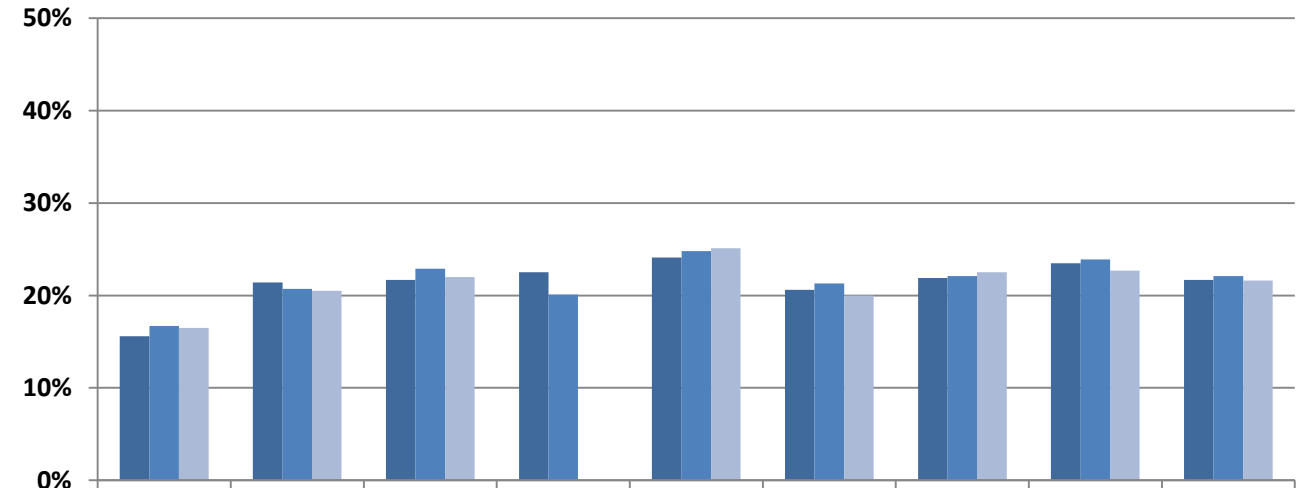
Indicator Description: CURRENT MARIJUANA USE. This measure shows the percentage of Maine residents who reported using marijuana in the past 30 days. This is presented for high school students and adults in Maine.

Why Indicator is Important: Marijuana can be addictive and is associated with increased risk for respiratory illnesses and memory impairment. Even occasional use can have consequences on learning and memory, muscle coordination, and mental health symptoms.

Data Source(s): MIYHS, 2009-2013; BRFSS, 2012.

Summary: In 2013, 17 percent of high school students in Aroostook reported having used marijuana one or more times in the past 30 days, compared to 22 percent statewide. Rates among public health districts have remained stable since 2009.

Figure 14. Percent of high school students by Public Health District who have used marijuana during past 30 days: 2009-2013

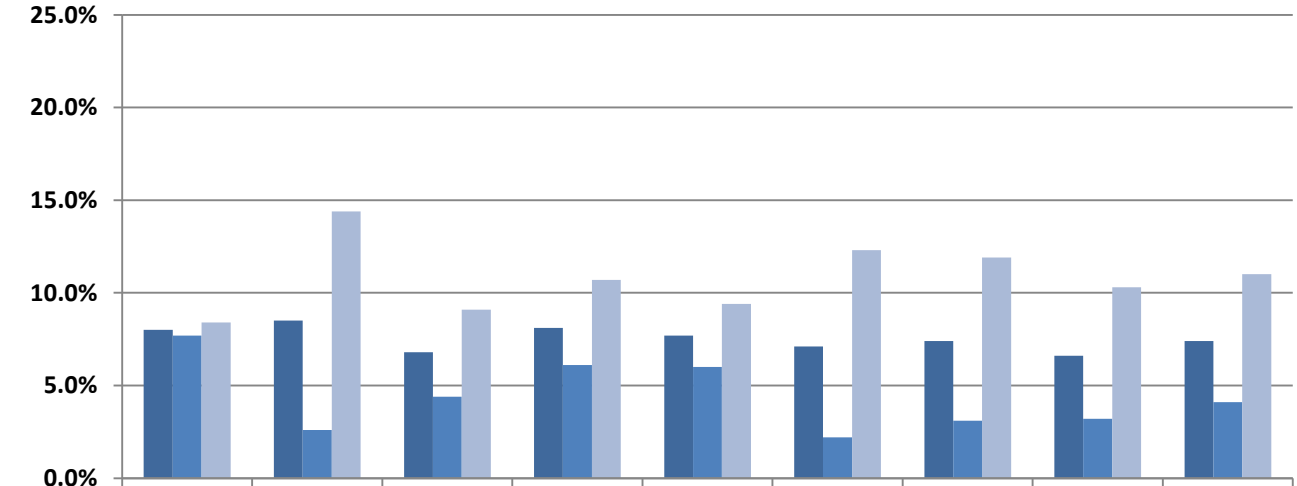


	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	16%	21%	22%	23%	24%	21%	22%	24%	22%
2011	17%	21%	23%	20%	25%	21%	22%	24%	22%
2013	17%	21%	22%		25%	20%	23%	23%	22%

Source: MIYHS

Summary: Among Aroostook adults, eight percent reported using any marijuana within the past 30 days. This was slightly greater than the statewide rate of 7.4 percent. Rates in Aroostook were slightly higher among males (8.4%) as compared to females (7.7%).

Figure 15. Percent of adults who have used marijuana during the past 30 days, by gender and Public Health District: 2012-13



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
Total	8.0%	8.5%	6.8%	8.1%	7.7%	7.1%	7.4%	6.6%	7.4%
Female	7.7%	2.6%	4.4%	6.1%	6.0%	2.2%	3.1%	3.2%	4.1%
Male	8.4%	14.4%	9.1%	10.7%	9.4%	12.3%	11.9%	10.3%	11.0%

Source: BRFSS

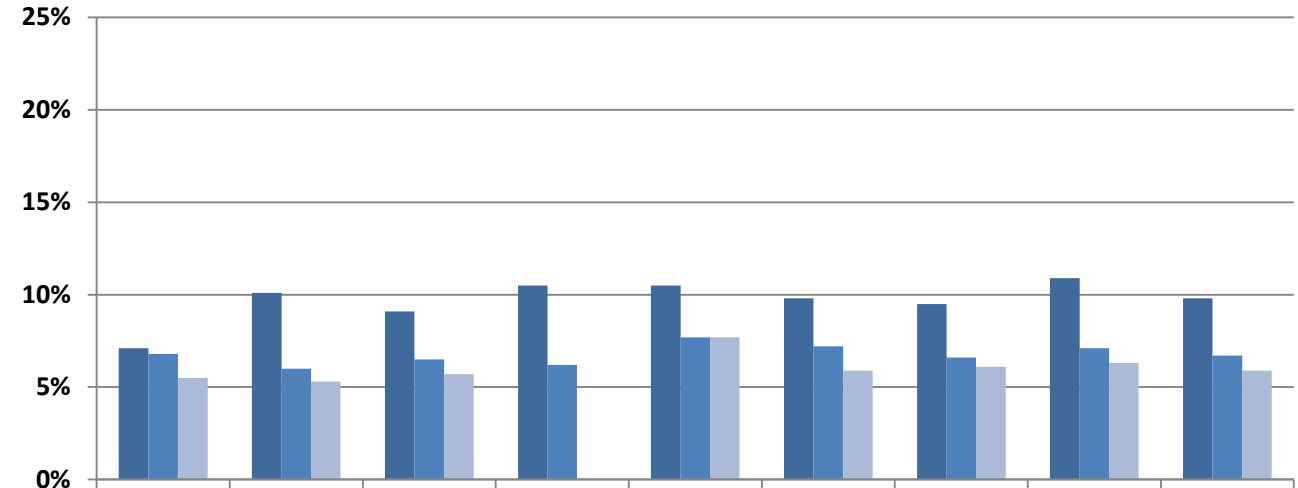
Indicator Description: LIFETIME COCAINE USE AMONG YOUTH. This indicator illustrates the percentage of Maine high school students who used cocaine at least once in their lifetime (i.e., ever).

Why Indicator is Important: Cocaine is highly addictive. Use of cocaine is associated with adverse health effects such as cardiac events, seizures, and stroke. It also increases the risk of cognitive impairment, injury, and crime.

Data Source(s): MIYHS, 2009-2013.

Summary: The percentage of Aroostook high school students reporting that they had used cocaine (in any form) during their lifetime has remained relatively stable since 2009; in 2013, the rate was on par with the statewide average (both 6%).

Figure 16. Percent of high school students by Public Health District that have used cocaine in any form during their lifetime: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	7%	10%	9%	11%	11%	10%	10%	11%	10%
2011	7%	6%	7%	6%	8%	7%	7%	7%	7%
2013	6%	5%	6%		8%	6%	6%	6%	6%

Source: MIYHS

Consequences Resulting from Substance Use and Abuse

Both individuals and communities suffer the consequences of substance abuse in terms of increased health care needs and criminal justice resources. While a great deal of information regarding substance use can be obtained from the data described in the previous section, information on the effects of that use on individuals and communities can be derived from what has come to be called “consequence” data. Consequences are defined as the social, economic and health problems associated with the use of alcohol and illicit drugs. Examples are things such as illnesses related to alcohol, drug overdose deaths, property and personal crimes, as well as driving accidents, poisonings and suicides that involve alcohol or drugs.

In recent years, Aroostook has observed relatively low rates concerning alcohol related crimes, automobile crashes, and drug overdoses. However, among public health districts, Aroostook had the third highest rate of drug affected babies and the highest drinking and driving rate among high school students. In addition, drug arrest rates in Aroostook made by law enforcement as well as Maine Drug Enforcement Agents have been among the highest in Maine for the past few years. Drug arrest rates have been driven mostly by offenses related to methamphetamine and synthetic cathinones.

Substance Use and Pregnancy

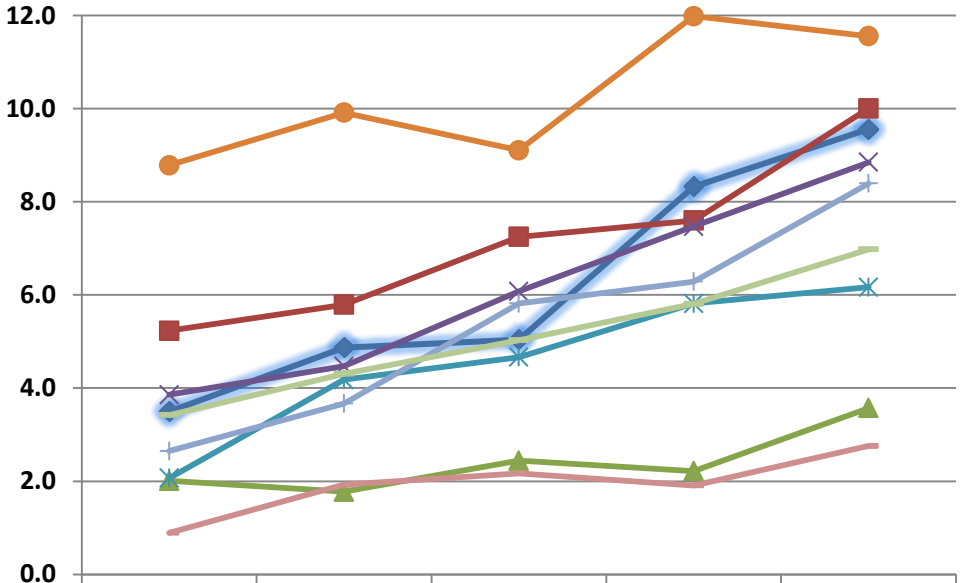
Indicator Description: BABIES BORN AFFECTED BY SUBSTANCES. This measure reflects the number of infants born in Maine where a healthcare provider reported to OCFS that there was reasonable cause to suspect the baby may be affected by drugs or alcohol or demonstrating withdrawal symptoms resulting from prenatal drug exposure (illicit or prescribed) or who have fetal alcohol spectrum disorders. This measure potentially excludes instances where the infant was exposed to substances and did not show withdrawal symptoms after birth, instances where the birth of an infant affected by substances was not reported to OCFS, and any other instances in which there were discrepancies between reporters when interpreting Title 22, §4011-A; notification of prenatal exposure to drugs or having fetal alcohol spectrum disorders.

Why Indicator is Important: Prenatal exposure to alcohol, tobacco, and illicit drugs has the potential to cause a wide spectrum of physical, emotional, and developmental problems for these infants. The harm caused to the child can be significant and long-lasting, especially if the exposure is not detected and the effects are not treated as soon as possible.

Data Source(s): OCFS/MACWIS, 2010-2014

Summary: The rate of drug affected babies in Aroostook steadily increased from 2009 (3.5 per 10,000 residents) to 2014 (9.6 per 10,000 residents). In 2014, Aroostook had the third highest rate among public health districts. In 2014, rates among public health districts ranged from 2.8 drug affected babies per 10,000 residents in York to 11.6 per 10,000 residents in Penquis.

Figure 17. Number of drug affected baby notifications, by Public Health District: 2010-2013



	2009	2010	2011	2012	2013
Aroostook	3.5	4.9	5.0	8.3	9.6
Central	5.2	5.8	7.2	7.6	10.0
Cumberland	2.0	1.8	2.4	2.2	3.6
Downeast	3.9	4.5	6.1	7.5	8.8
Midcoast	2.1	4.2	4.7	5.8	6.2
Penquis	8.8	9.9	9.1	12.0	11.6
Western	2.6	3.7	5.8	6.3	8.4
York	0.9	1.9	2.2	1.9	2.8
Maine	3.4	4.3	5.0	5.8	7.0

Source: OCFS/MACWIS

Referral Services

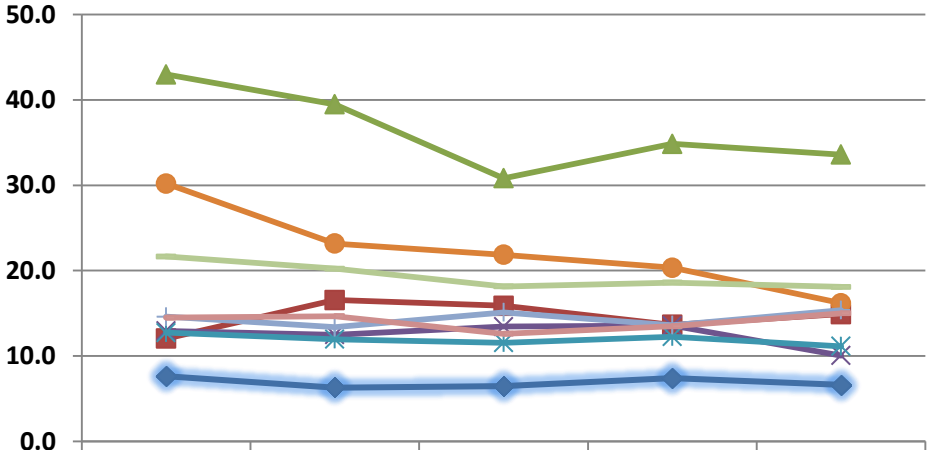
Indicator Description: INFORMATION CALLS FOR REFERRAL SERVICES.
2-1-1 Maine is a telephone and internet service that provides information and referrals to a wide range of health and human services. This indicator reflects the number of calls received by Maine 2-1-1 where the callers were seeking services related to the treatment of substance use. Callers are referred to support services such as alcohol anonymous meetings, residential treatment programs, outpatient counseling/certification programs, and medication assisted treatment programs. Virtually all callers are seeking treatment for themselves, family members, friends, or significant others.

Why Indicator is Important: The data collected provides valuable information serving as a barometer of health and human service needs related to substance use in the state.

Data Source(s): 2-1-1 Maine, 2010-2014

Summary: In 2104, Aroostook observed just over six 2-1-1 Maine calls per 10,000 residents related to substance use. From 2010 to 2014, Aroostook held the lowest rates among public health districts. Aroostook's rates have remained relatively unchanged over the past several years.

Figure 18. Number of 2-1-1 referral calls relating to substance use per 10,000 residents, by Public Health District: 2010-2013



	2010	2011	2012	2013	2014
Aroostook	7.7	6.3	6.5	7.4	6.6
Central	12.0	16.6	15.9	13.7	14.9
Cumberland	43.0	39.5	30.8	34.9	33.6
Downeast	12.9	12.5	13.4	13.6	10.1
Midcoast	12.7	12.0	11.6	12.3	11.2
Penquis	30.2	23.2	21.9	20.4	16.2
Western	14.6	13.4	15.1	13.6	15.4
York	14.5	14.7	12.6	13.5	15.0
Maine	21.7	20.2	18.2	18.6	18.1

Source: 2-1-1 Maine

Criminal Justice Involvement

Indicator Description: ANNUAL VIOLENT CRIME RATE. This indicator shows the number of violent crimes reported to the police, per 10,000 people. Violent crimes include murder, rape, robberies, and aggravated assaults. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

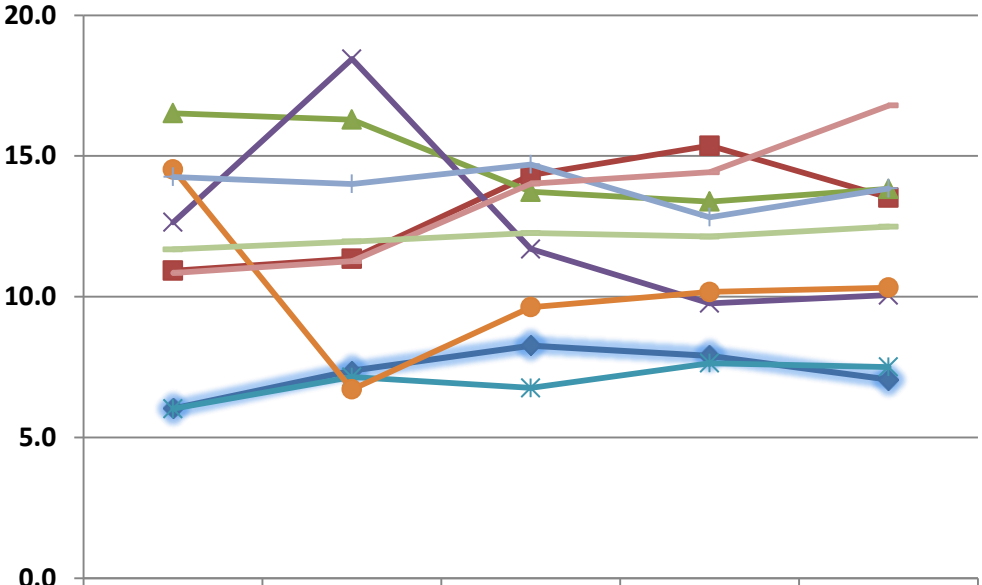
Operationalized as: $\left(\frac{\#\ of\ violent\ crimes}{population}\right) \times 10{,}000$

Why Indicator is Important: Violence is associated with alcohol, though the causal pathway is not completely understood. Drinking on the part of the victim or a perpetrator can increase the risk of assaults and assault-related injuries. Estimates have indicated that at least 23 percent of sexual assaults and 30 percent of physical assaults can be attributed to alcohol. Reported violent crimes are an under-report of the total number of actual violent crimes.

Data Source(s): DPS, UCR, 2009-2013.

Summary: In 2013, there were 7.1 violent crimes per 10,000 people in Aroostook, compared to 12.5 per 10,000 people statewide. Aroostook has consistently been lower than the state rate for violent crime. Although not shown in the chart, the number of violent crimes in Aroostook decreased from 59 in 2011 to 49 in 2013; representing a decrease of 17 percent.

Figure 19. Violent crime rate per 10,000, by Public Health District: 2009-2013



	2009	2010	2011	2012	2013
Aroostook	6.0	7.4	8.3	7.9	7.1
Central	10.9	11.4	14.3	15.4	13.5
Cumberland	16.5	16.3	13.7	13.4	13.8
Downeast	12.6	18.4	11.7	9.8	10.1
Midcoast	6.0	7.1	6.8	7.6	7.5
Penquis	14.5	6.7	9.6	10.2	10.3
Western	14.3	14.0	14.7	12.8	13.8
York	10.8	11.3	14.0	14.4	16.8
Maine	11.7	12.0	12.3	12.1	12.5

Source: DPS; UCR

Indicator Description: ANNUAL ALCOHOL-RELATED ARREST RATE. This indicator reflects arrests related to alcohol per 10,000 people. Alcohol-related arrests include Operating Under the Influence (OUI), liquor law violations, and drunkenness. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

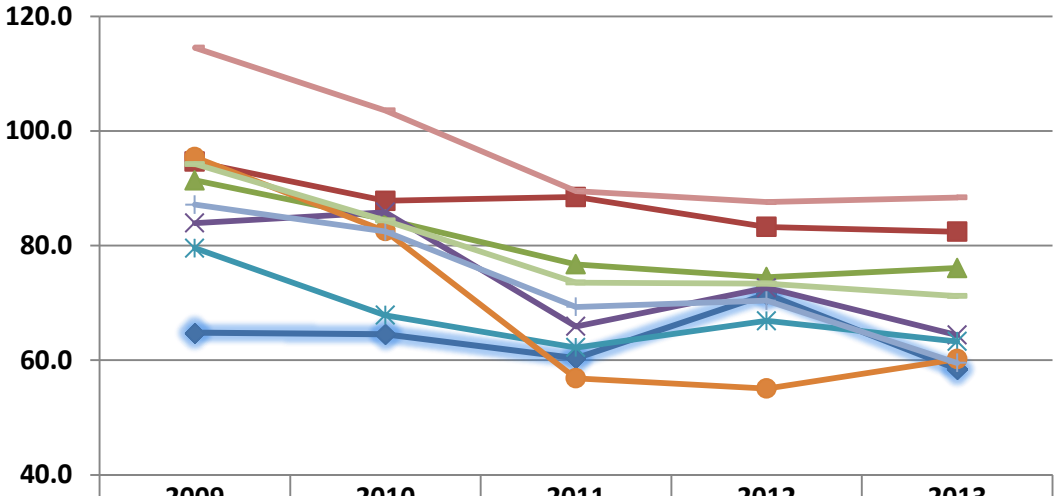
Operationalized as: $\left(\frac{\#\ of\ alcohol\ arrests}{population}\right) \times 10{,}000$

Why Indicator is Important: OUI and liquor law arrest rates can be an indication of the rate of criminal behavior, but it is important to note that they are also an *indication of the level of law enforcement*. Arrest rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed. The educational component of Maine's Driver Education and Evaluation Program serviced 5,192 Maine residents during the 2014 fiscal year.

Data Source(s): DPS, UCR, 2009-2013.

Summary: After observing a spike in 2012 (70.5 per 10,000), Aroostook's alcohol-related arrest rate dropped to 58.5 per 10,000 residents in 2013; this was the lowest rate among public health districts. The statewide alcohol-related arrest rate was 71.2 per 10,000 residents in 2013. Overall, most public health districts have observed a decline in alcohol-related arrests over the past several years.

Figure 20. Alcohol-related arrest rate per 10,000, by Public Health District: 2009-2013



	2009	2010	2011	2012	2013
Aroostook	64.8	64.6	60.4	71.5	58.5
Central	94.6	87.8	88.5	83.3	82.4
Cumberland	91.4	84.6	76.7	74.5	76.1
Downeast	83.9	85.8	65.9	72.6	64.4
Midcoast	79.6	67.8	62.2	66.9	63.3
Penquis	95.4	82.5	56.9	55.1	60.2
Western	87.1	82.5	69.3	70.4	59.5
York	114.5	103.6	89.5	87.6	88.4
Maine	94.2	84.4	73.5	73.4	71.2

Source: DPS; UCR

Indicator Description: ANNUAL DRUG-RELATED ARREST RATE. This indicator reflects the number of arrests (made by all local and state law enforcement) that were related to drugs per 10,000 people. Drug-related arrests include manufacturing, sales, and possession. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time as well as make relative comparisons between small and large population areas.

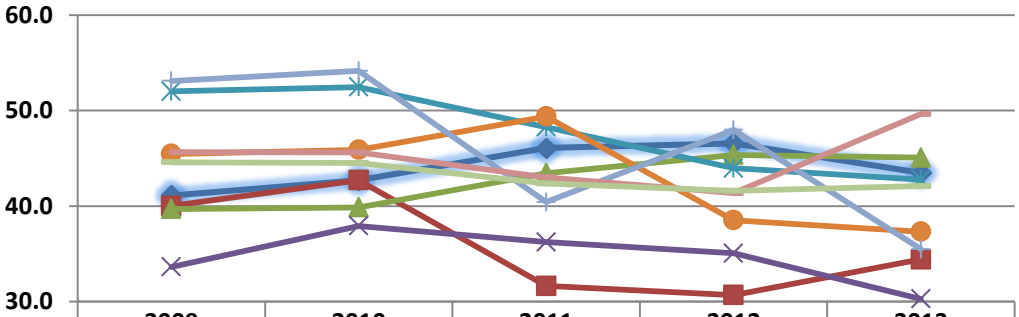
Operationalized as: $\left(\frac{\#\ of\ drug\ arrests}{population}\right) \times 10{,}000$

Why Indicator is Important: Arrest rates for drug sales, manufacturing and drug possession can be an indication of the rate of criminal behavior, but it is important to note that they are also an *indication of the level of law enforcement*. Arrests rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed.

Data Source(s): DPS, UCR, 2009-2013.

Summary: In 2013, there were 43.5 drug-related arrests per 10,000 people in Aroostook, compared to 42.1 per 10,000 people statewide. Aroostook has consistently held some of the highest rates among public health districts since 2011. Although not shown, Aroostook had a total of 302 drug related arrests by local law enforcement in 2013.

Figure 21. Drug-related arrest rate per 10,000, by Public Health District: 2009-2013

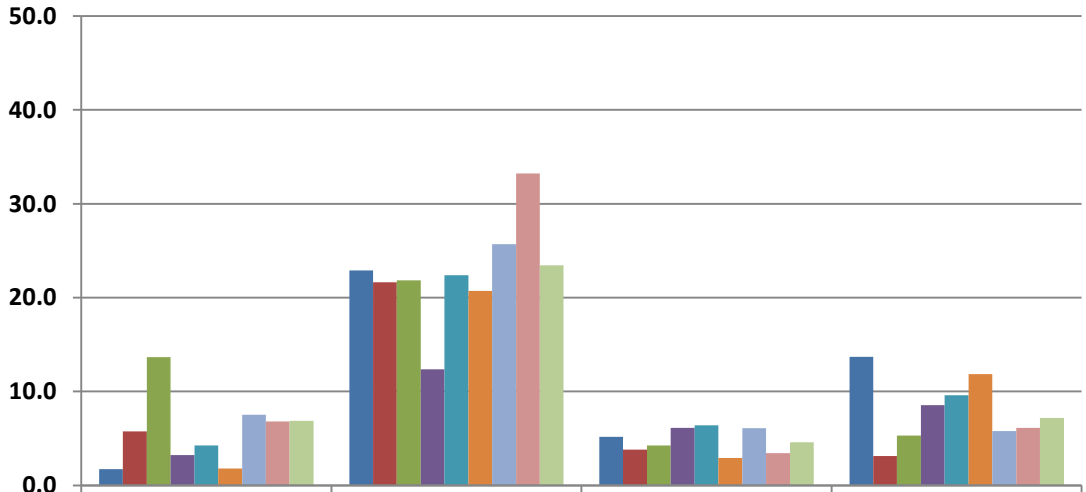


	2009	2010	2011	2012	2013
Aroostook	41.1	42.7	46.1	46.6	43.5
Central	40.0	42.7	31.6	30.7	34.4
Cumberland	39.7	39.9	43.4	45.4	45.1
Downeast	33.6	37.9	36.2	35.0	30.3
Midcoast	52.0	52.5	48.3	44.0	42.8
Penquis	45.5	45.9	49.4	38.5	37.3
Western	53.1	54.2	40.4	48.0	35.5
York	45.6	45.6	43.0	41.4	49.6
Maine	44.6	45	42.4	41.6	42.1

Source: DPS; UCR

Summary: In 2013, most drug related arrests by local and state law enforcement were related to marijuana (22.9 per 10,000 residents) followed by other dangerous non-narcotics (13.7 per 10,000), synthetic narcotics (5.2 per 10,000), and opium, cocaine, and derivatives (1.7 per 10,000).

Figure 22. Drug-related arrest rate per 10,000, by drug type and Public Health District: 2013



	Opium, cocaine, and derivatives*	Marijuana	Synthetic narcotics	Other dangerous non-narcotics**
Aroostook	1.7	22.9	5.2	13.7
Central	5.7	21.7	3.8	3.1
Cumberland	13.7	21.9	4.3	5.3
Downeast	3.2	12.4	6.1	8.6
Midcoast	4.3	22.4	6.4	9.6
Penquis	1.8	20.7	2.9	11.9
Western	7.5	25.7	6.1	5.8
York	6.8	33.2	3.4	6.1
Maine	6.9	23.4	4.6	7.2

Source: DPS; UCR

**Derivatives include cocaine/crack, codeine, heroin, and morphine.*

***Other dangerous non-narcotics include but are not limited to benzodiazepines, steroids, stimulants, synthetic cannabis, bath salts, methamphetamine, hallucinogens, and barbiturates.*

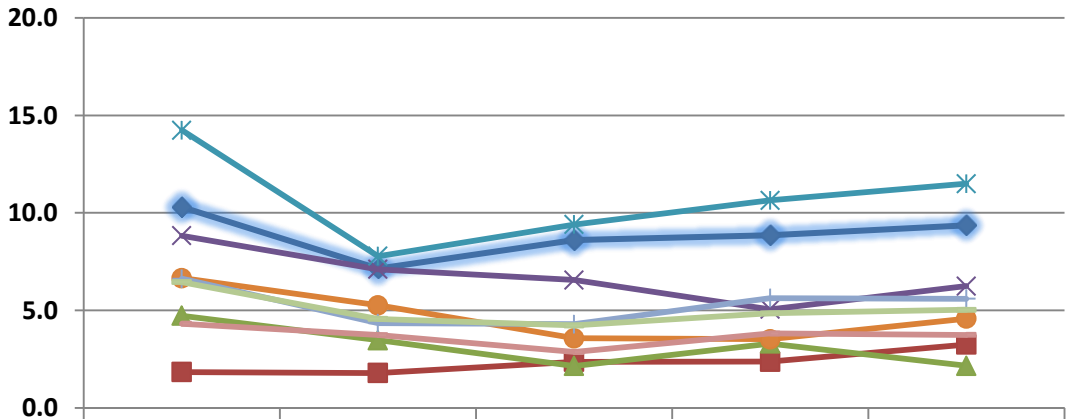
Indicator Description: MAINE DEA DRUG OFFENSE ARRESTS BY TYPE. This indicator reflects drug offense arrests made by the Maine's Drug Enforcement Agency, overall and by drug type. The MDEA, through its eight regional multi-jurisdictional task forces, is the lead state agency in confronting drug trafficking crime. This indicator differs from the previous drug-related arrest data in that it only tracks MDEA efforts and does not encompass all activity within Maine law enforcement agencies.

Why Indicator is Important: Drug offense arrest rates can be an indication of the rate of criminal behavior, but it is important to note that they are also an indication of the level of law enforcement. Drug arrest rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed.

Data Source(s): MDEA-UCR, 2010-2014

Summary: In 2014, there were 9.4 drug offense arrests per 10,000 residents in Aroostook; the second highest rate among public health districts in Maine. Rates have remained comparatively high since 2010.

Figure 23. Maine DEA Drug offense arrests per 10,000 residents, by Public Health District: 2010-2014

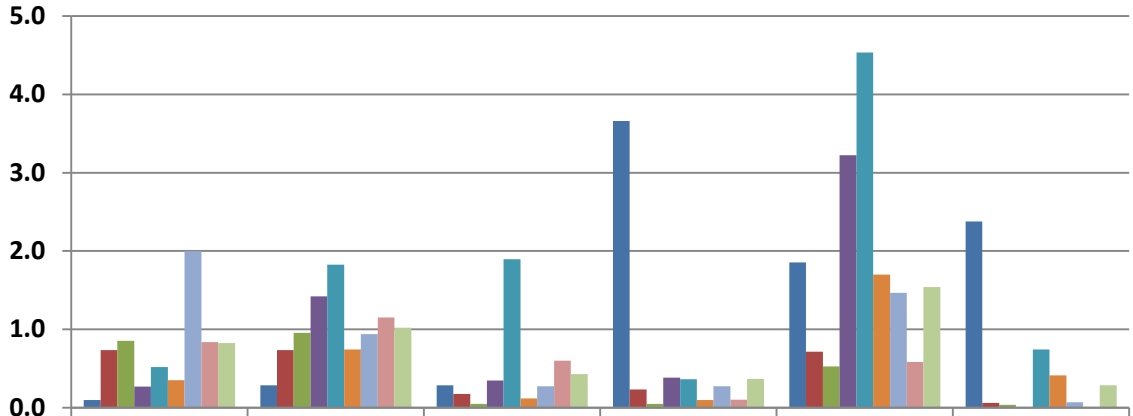


	2010	2011	2012	2013	2014
Aroostook	10.3	7.1	8.6	8.9	9.4
Central	1.8	1.8	2.4	2.4	3.3
Cumber.	4.7	3.5	2.1	3.3	2.2
Downeast	8.8	7.1	6.6	5.1	6.2
Midcoast	14.2	7.8	9.4	10.6	11.5
Penquis	6.6	5.3	3.6	3.5	4.6
Western	6.6	4.3	4.3	5.6	5.6
York	4.3	3.7	2.9	3.8	3.7
Maine	6.4	4.6	4.2	4.8	5.0

Source: MDEA-UCR

Summary: During 2012-14 (combined years), most drug offense arrests in Aroostook were related to methamphetamine (3.7 arrests per 10,000) followed by synthetic cathinones (2.4 arrests per 10,000), pharmaceutical narcotics (1.9 arrests per 10,000). Although not shown, during the 2012-14 period, 53 percent (77 arrests) of methamphetamine related arrests occurred in Aroostook.

Figure 24. Maine DEA Drug offense arrests per 10,000 residents, by Public Health District: 2012-14



	Cocaine/crack	Heroin	Marijuana	Methamph.	Pharm-narcotic	*Synthetic cathinone
Aroostook	0.1	0.3	0.3	3.7	1.9	2.4
Central	0.7	0.7	0.2	0.2	0.7	0.1
Cumberland	0.9	1.0	0.0	0.0	0.5	0.0
Downeast	0.3	1.4	0.3	0.4	3.2	0.0
Midcoast	0.5	1.8	1.9	0.4	4.5	0.7
Penquis	0.4	0.7	0.1	0.1	1.7	0.4
Western	2.0	0.9	0.3	0.3	1.5	0.1
York	0.8	1.2	0.6	0.1	0.6	0.0
Maine	0.8	1.0	0.4	0.4	1.5	0.3

Source: MDEA-UCR

**Synthetic cathinones* are *synthetic derivatives of an alkaloid that are used as drugs for their stimulating properties.*

Driving Under the Influence

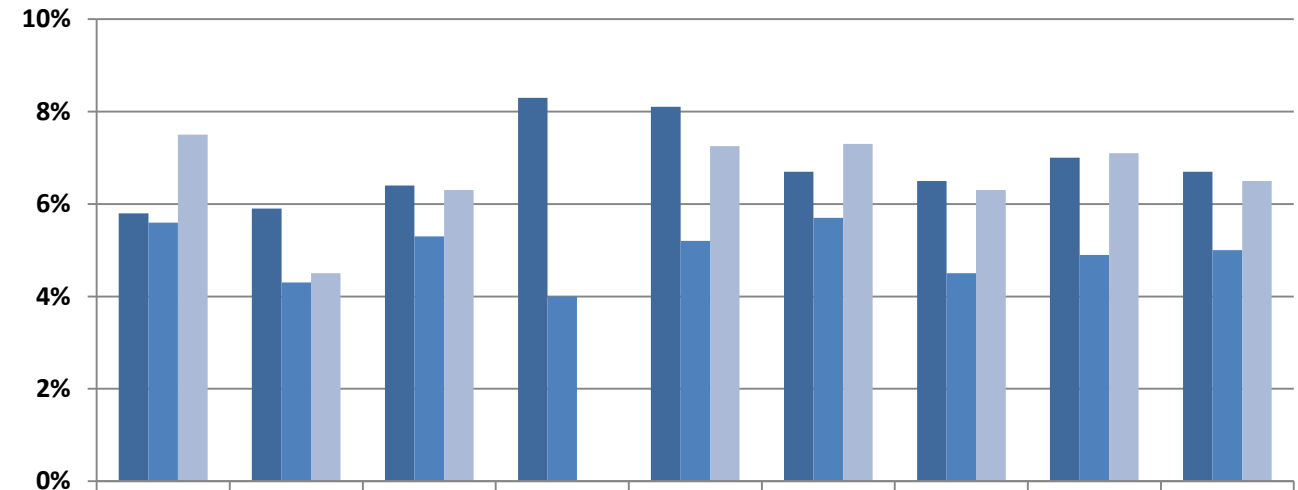
Indicator Description: DRINKING AND DRIVING AMONG YOUTH. This measure shows the proportion of high school students who reported that they drove a car after consuming alcohol at least once within 30 days prior to taking the survey.

Why Indicator is Important: Operating a vehicle after consuming alcohol increases the risk of motor vehicle crashes, injuries and death.

Data Source(s): MIYHS, 2009-2013.

Summary: In 2013, eight percent of high school students in Aroostook reported driving a vehicle at least once after drinking alcohol in the past 30 days, similar to the statewide rate of seven percent.

Figure 25. Percent of high school students by Public Health District who reported drinking and driving during the past 30 days: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	6%	6%	6%	8%	8%	7%	7%	7%	7%
2011	6%	4%	5%	4%	5%	6%	5%	5%	5%
2013	8%	5%	6%		7%	7%	6%	7%	7%

Source: MIYHS

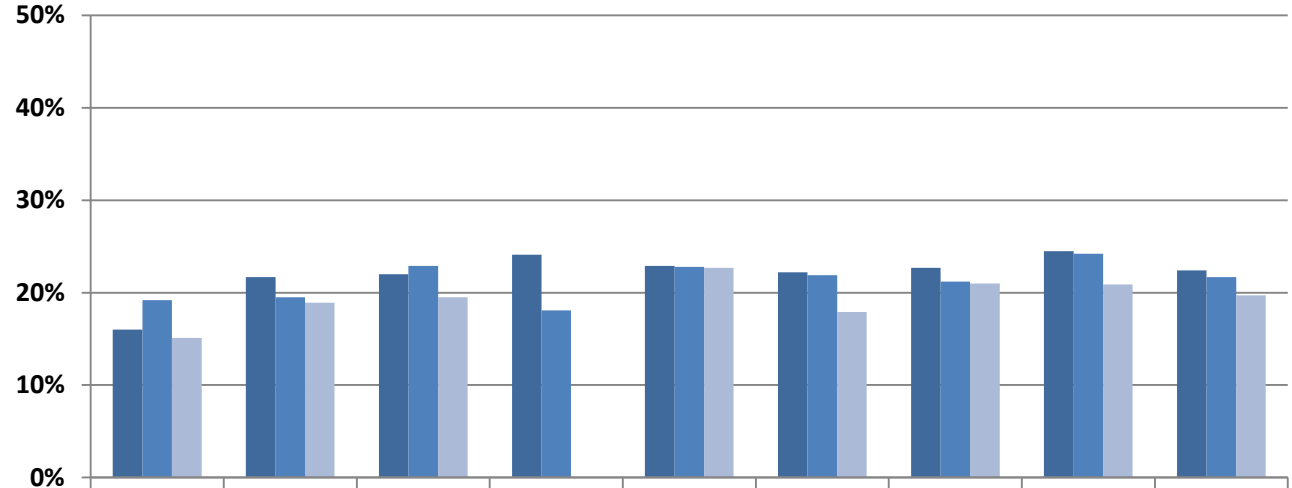
Indicator Description: YOUTH AS PASSENGERS IN VEHICLES DRIVEN BY INDIVIDUALS USING ILLEGAL DRUGS. This measure shows the proportion of high school students who reported that within 30 days prior to taking the survey they were a passenger in a car being operated by an individual who had consumed illegal drugs.

Why Indicator is Important: Operating a vehicle while under the influence of drugs increases the risk of motor vehicle crashes, injuries and death.

Data Source(s): MIYHS, 2009-2013.

Summary: From 2011 to 2013 the rate of students in Aroostook who reported that, within the past 30 days, they had been passengers in a vehicle operated by someone who had taken illegal drugs decreased from 19 percent to 15 percent; this is lower than the statewide rate (20%).

Figure 26. Percent of high school students by Public Health District who rode in a vehicle driven by someone who had taken illegal drugs: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	16%	22%	22%	24%	23%	22%	23%	25%	22%
2011	19%	20%	23%	18%	23%	22%	21%	24%	22%
2013	15%	19%	20%		23%	18%	21%	21%	20%

Source: MIYHS

Indicator Description: ALCOHOL/DRUG-INVOLVED MOTOR VEHICLE CRASH RATE. This indicator shows the number of motor vehicle crashes in which alcohol or drugs were a factor per 10,000 people. Due to new data collection regulations, crash rate data is no longer separated by alcohol and drugs. Alcohol and drugs are now combined into one rate. Alcohol/drug-involved crashes means that at least one driver had consumed alcohol or drugs prior to the crash. The rate per 10,000 allows us to see the frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

Operationalized as: $\left(\frac{\#\ of\ alcohol/drug-involved\ crashes}{population}\right) \times 10{,}000$

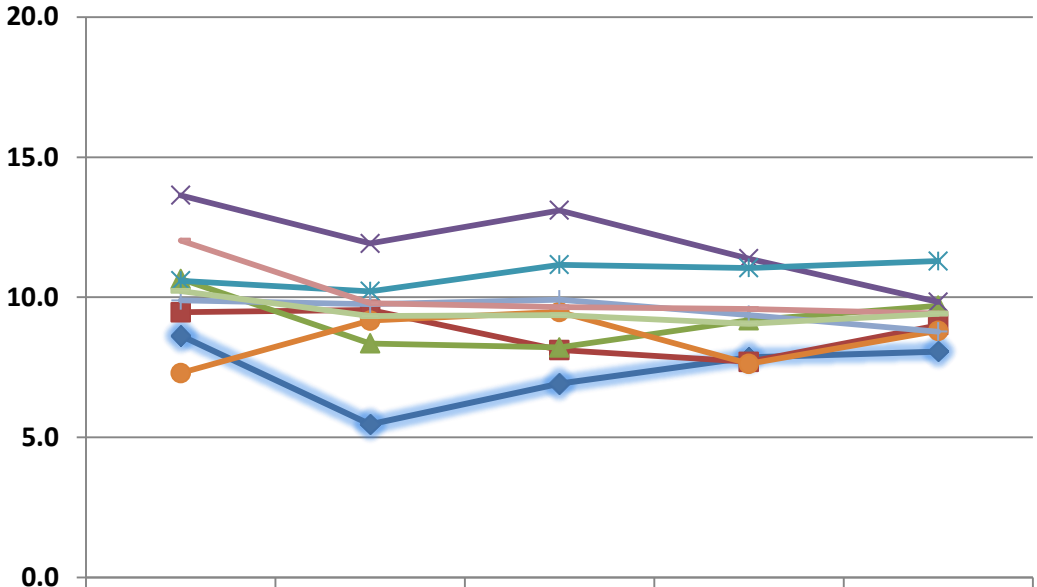
Why Indicator is Important: Motor vehicle crashes are the second-leading cause of traumatic brain injury, with 27 percent of traumatic brain injuries occurring from motor vehicle crashes.[2] In 2009, alcohol was attributed to 96 percent of the alcohol/drug-related crashes statewide.

Data Source(s): MDOT/MBHS, 2010-2014.

Summary: Although Aroostook still has one of the lowest alcohol/drug involved crash rates among public health districts, the rate has increased from 2011 (5.5 crashes per 10,000 residents) to 2014 (8.1 crashes per 10,000 residents). Although not shown, the number of alcohol/drug related car crashes increased by 44 percent from 2011 (39 crashes) to 2014 (59 crashes).

[2] *2007 Maine Injury Report*, Maine Center for Disease Control, Injury Prevention Program. Retrieved 7/11/2014 from http://www.maine.gov/dhhs/mecdc/population-health/inj/documents/2007maineinjuryreport.pdf

Figure 27. Alcohol/Drug-related motor vehicle crash rate per 10,000, by Public Health District: 2010-2014



	2010	2011	2012	2013	2014
Aroostook	8.6	5.5	6.9	7.9	8.1
Central	9.5	9.5	8.1	7.7	9.0
Cumber.	10.7	8.3	8.2	9.2	9.7
Downeast	13.6	11.9	13.1	11.4	9.8
Midcoast	10.6	10.2	11.2	11.0	11.3
Penquis	7.3	9.2	9.5	7.6	8.8
Western	9.9	9.7	9.9	9.4	8.8
York	12.0	9.8	9.6	9.6	9.4
Maine	10.2	9.3	9.4	9.1	9.4

Source: MDOT/MBHS

Hospital Visits Related to Substance Use

Indicator Description: INPATIENT ADMISSIONS RELATED TO SUBSTANCE USE. This indicator shows the number of inpatient hospital admissions (per 10,000 people) where alcohol, opiates, or other drugs were recorded as the primary diagnosis for which services were sought at admission. “Inpatient” refers to a patient whose treatment needs at least one night's residence in a hospital. The substance for which treatment was received was identified through hospital codes (ICD-9 codes) and includes those related to alcohol and psychoactive substances (303-305). More than one substance may be involved in a single visit. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

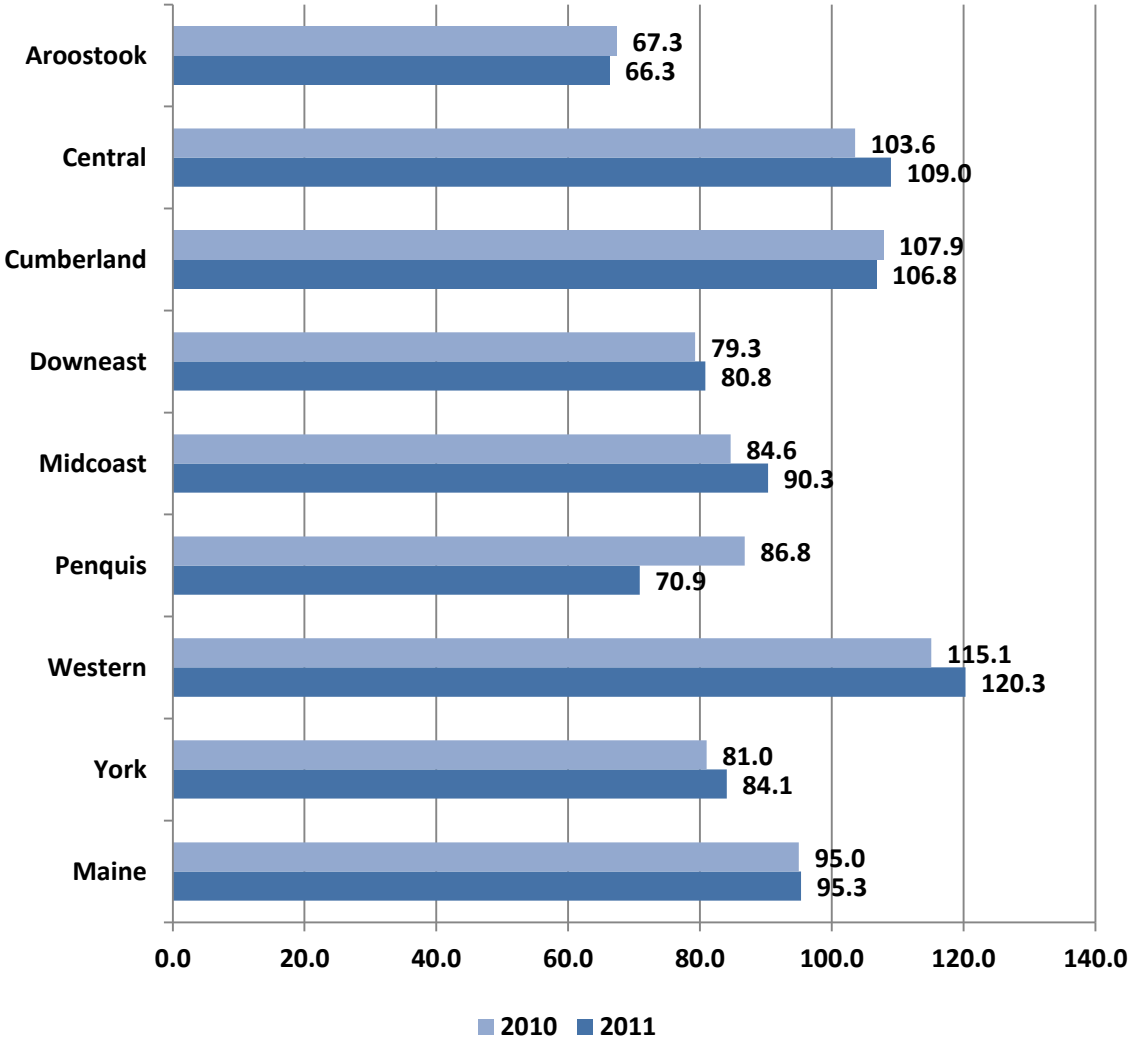
Operationalized as: $\left(\frac{\#\ of\ inpatient\ hospitalizations}{population}\right) \times 10{,}000$

Why Indicator is Important: Hospital admissions related to substance use are an indication of injury sustained through substance use and the impact it has on the healthcare system.

Data Source(s): MHDO, 2010 and 2011.

Summary: The inpatient admissions rate due to substance use in Aroostook decreased slightly from 2010 (67.3 admissions per 10,000 residents) to 2011 (66.3 admissions per 10,000). In 2011, Aroostook had a lower inpatient substance use rate than the state (95.3 admissions per 10,000) and had the lowest rate among public health districts.

Figure 28. Inpatient hospital admissions (per 10,000 people) related to substance use*, by Public Health District: 2010, 2011

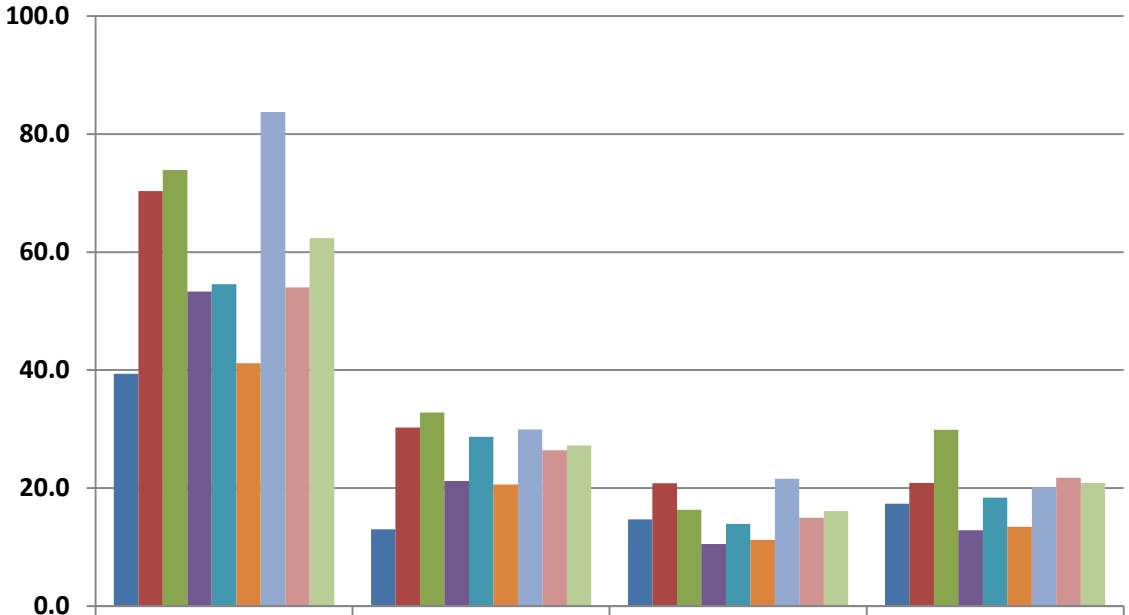


Source: MHDO

**Visits may involve multiple substances*

Summary: In 2011, most inpatient admissions due to substance use in Aroostook were related to alcohol (39.4 admissions per 10,000), followed by marijuana (14.7 admissions per 10,000), opiates (13 admissions per 10,000), and other drugs (17.4 admissions per 10,000). Among public health districts, Aroostook held the lowest inpatient rate due to alcohol as well as the lowest inpatient rate related to opiates.

Figure 29. Inpatient hospital admissions (per 10,000 people) related to substance use*, by Public Health District and drug type: 2011



	Alcohol	Opiate	Marijuana	Other drugs
Aroostook	39.4	13.0	14.7	17.4
Central	70.4	30.3	20.8	20.9
Cumberland	73.9	32.8	16.3	29.9
Downeast	53.3	21.2	10.5	12.8
Midcoast	54.6	28.7	13.9	18.4
Penquis	41.2	20.6	11.2	13.4
Western	83.8	30.0	21.6	20.2
York	54.0	26.4	15.0	21.7
Maine	62.3	27.2	16.1	20.9

Source: MHDO

**Visits may involve multiple substances*

Indicator Description: OUTPATIENT HOSPITAL VISITS RELATED TO SUBSTANCE USE. This indicator shows the of outpatient hospital admissions (per 10,000 people) where alcohol, opiates, or other drugs was recorded as the primary diagnosis for which services were received. "Outpatient" refers to patients who receive treatment at a hospital or clinic but are not admitted overnight. The substance for which treatment was received was identified through hospital codes (ICD-9 codes) and includes those related to alcohol psychoactive substances (303-305). The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

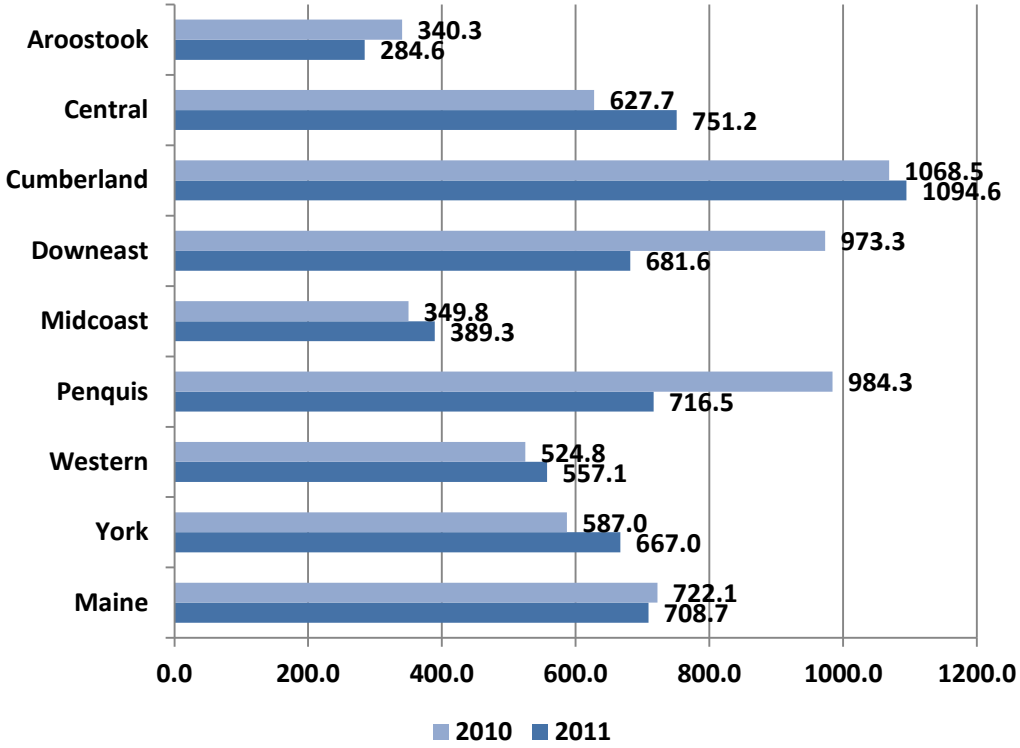
Operationalized as: $\left(\frac{\#\ of\ outpatient\ hospitalizations}{population}\right) \times 10{,}000$

Why Indicator is Important: Outpatient hospital visits related to substance use are an indication of injury sustained through substance use and the impact it has on the healthcare system.

Data Source(s): MHDO, 2010 and 2011

Summary: From 2010 to 2011, the outpatient admission rate due to substance use in Aroostook decreased from 340.3 admissions per 10,000 residents to 284.6 admissions per 10,000 residents. In 2011, Aroostook had a much lower rate than the state (708.7 admissions per 10,000) and held the lowest rate among public health districts.

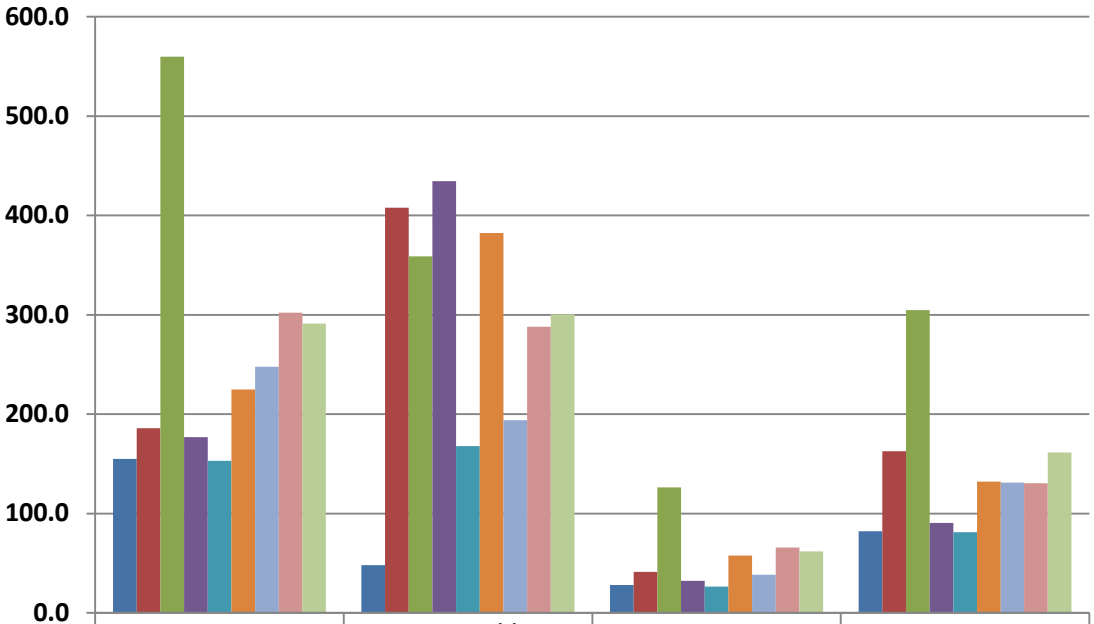
Figure 30. Outpatient hospital admissions (per 10,000 people) related to substance use,* by Public Health District: 2010, 2011



Source: MHDO
**Visits may involve multiple substances*

Summary: In 2011, Aroostook had the second lowest alcohol-related outpatient admission rate among public health districts (154.9 admissions per 10,000); this rate was lower than that of the state (291.1 admissions per 10,000). Aroostook also held the lowest opiate-related outpatient rate at 48 admissions per 10,000 residents; this was much lower than the statewide rate (330.4 admissions per 10,000).

Figure 31. Outpatient hospital admissions (per 10,000 people) related to substance use*, by Public Health District and drug type: 2011



	Alcohol	Opiate**	Marijuana	Other drugs
Aroostook	154.9	48.2	28.2	82.2
Central	185.8	407.9	41.2	162.9
Cumberland	559.9	359.0	126.4	304.8
Downeast	176.9	434.7	32.3	90.6
Midcoast	153.1	167.8	26.3	81.3
Penquis	224.9	382.3	57.8	132.2
Western	247.9	193.9	38.2	131.2
York	302.1	288.0	65.9	130.5
Maine	291.1	300.4	61.8	161.4

Source: MHDO
**Visits may involve multiple substances*
***Includes prescription narcotics, methadone, and heroin.*

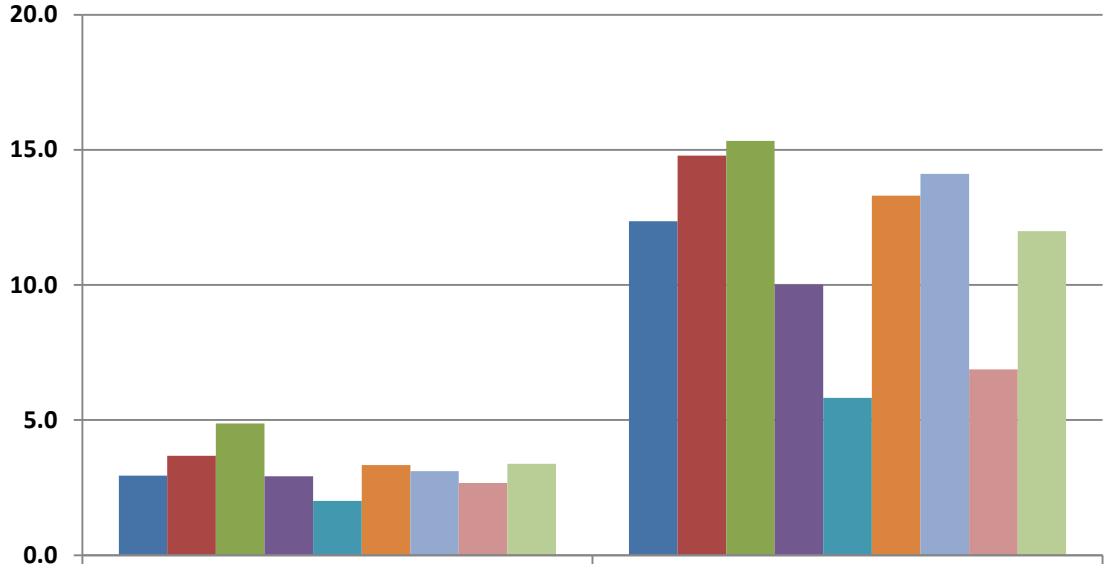
Indicator Description: POISONING CASES DOCUMENTED BY THE POISON CENTER. This measure reflects the rate of calls to the Northern New England Poison Center in which the Center determined that a poisoning occurred. These calls are for the state of Maine only. The Center reports poisonings in three categories: unintentional, meaning those that are accidental; suspected substance abuse cases, meaning cases where the Center believes the intent is for an individual to get high; and suspected suicides, meaning staff at the Center determine that the individual attempted suicide. The categories reflect the caller's self-report and are not considered clinical or medical diagnoses.

Why Indicator is Important: The exposure to and ingestion of damaging substances can have many physiologic side effects. Poisonings can be influenced by programs to prevent substance abuse, accidental poisoning, suicide and fatal interaction among medications.

Data Source(s): NNEPC, 2012-14

Summary: During the period of 2012-14 the Poison Center received 12.4 calls per 10,000 residents in Aroostook that were suspected to be attempted suicide; this was similar to the statewide rate (12 calls per 10,000 residents). Within the same period, Aroostook observed 2.9 calls per 10,000 residents that were suspected to be substance abuse; this was also on par with the statewide rate of 3.4 calls per 10,000 residents.

Figure 32. Number of poisonings reported to New England Poison Center 10,000 residents, by intent and Public Health District: 2012-14

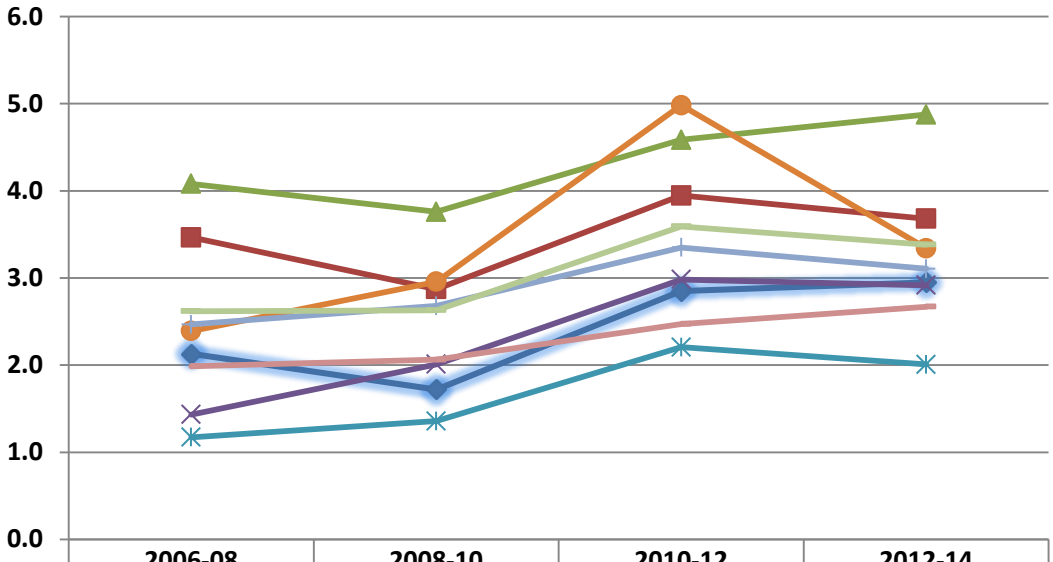


	Suspected substance abuse	Suspected suicide attempt
Aroostook	2.9	12.4
Central	3.7	14.8
Cumber.	4.9	15.3
Downeast	2.9	10.0
Midcoast	2.0	5.8
Penquis	3.3	13.3
Western	3.1	14.1
York	2.7	6.9
Maine	3.4	12.0

Source: NNEPC

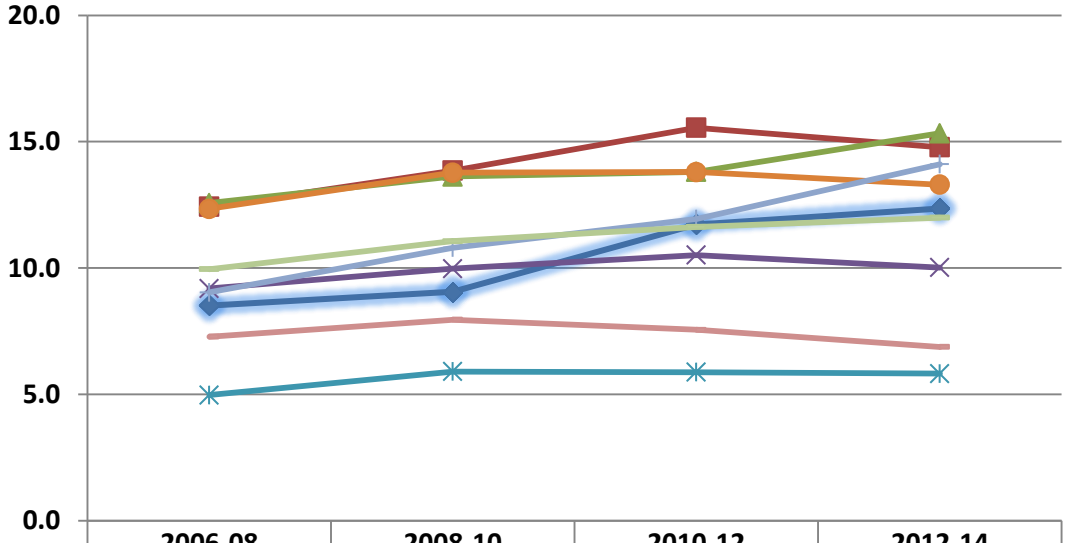
Summary: Aroostook's rate for calls suspected to be substance abuse increased from 1.7 calls per 10,000 residents in 2008-10 to 2.9 calls per 10,000 in 2012-14. As for calls suspected to be suicide attempts, Aroostook's rate increased from 9.1 calls per 10,000 residents in 2008-10 to 12.4 calls per 10,000 residents in 2012-14.

Figure 33. Number of poisonings reported to New England Poison Center suspected to be substance abuse per 10,000 residents, by Public Health District: 2012-14



	2006-08	2008-10	2010-12	2012-14
Aroostook	2.1	1.7	2.8	2.9
Central	3.5	2.9	3.9	3.7
Cumber.	4.1	3.8	4.6	4.9
Downeast	1.4	2.0	3.0	2.9
Midcoast	1.2	1.4	2.2	2.0
Penquis	2.4	3.0	5.0	3.3
Western	2.5	2.7	3.4	3.1
York	2.0	2.1	2.5	2.7
Maine	2.6	2.6	3.6	3.4

Figure 34. Number of poisonings reported to New England Poison Center suspected to be suicide attempts per 10,000 residents, by Public Health District: 2012-14



	2006-08	2008-10	2010-12	2012-14
Aroostook	8.5	9.1	11.7	12.4
Central	12.4	13.9	15.6	14.8
Cumber.	12.6	13.6	13.8	15.3
Downeast	9.2	10.0	10.5	10.0
Midcoast	5.0	5.9	5.9	5.8
Penquis	12.3	13.8	13.8	13.3
Western	9.0	10.8	11.9	14.1
York	7.3	8.0	7.6	6.9
Maine	10.0	11.1	11.6	12.0

Overdoses and Related Deaths

Indicator Description: OVERDOSES. This indicator shows the rate of persons receiving help from Emergency Medical Services (EMS) related to an overdose.

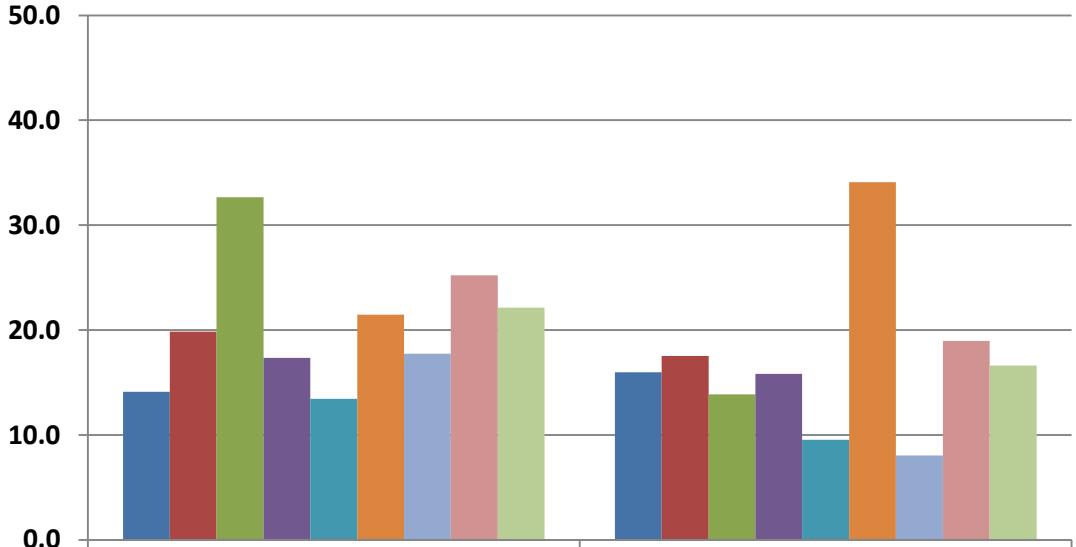
Why Indicator is Important: Overdosing on a substance can cause serious physical harm resulting in hospitalization and even death. Responding to overdoses also uses valuable EMS resources. The rate per 10,000 allows us to see the frequency with which an occurrence happens within a population over time, as well as make relative comparisons between small and large population areas. In this case, the base of 10,000 people was used due to small numbers.

Operationalized as: $\left(\frac{\#\ of\ overdose\ deaths}{population}\right) \times 10{,}000$

Data Source(s): EMS, 2011-2014

Summary: In 2014, Aroostook had the second lowest rate of drug/medication overdose responses among public health districts with 14.1 per 10,000 residents. This was compared to the statewide rate of 22.2 drug/medication responses per 10,000 residents. As for overdose responses related to alcohol, Aroostook held a rate of 16 per 10,000 residents; this was slightly lower than the state average (16.6 per 10,000). While Aroostook's rate of overdose responses classified as drug/medication related has remained relatively stable since the 2011, the rate of overdose responses related to alcohol increased from 11.2 per 10,000 residents in 2011 to 16 per 10,000 residents in 2014.

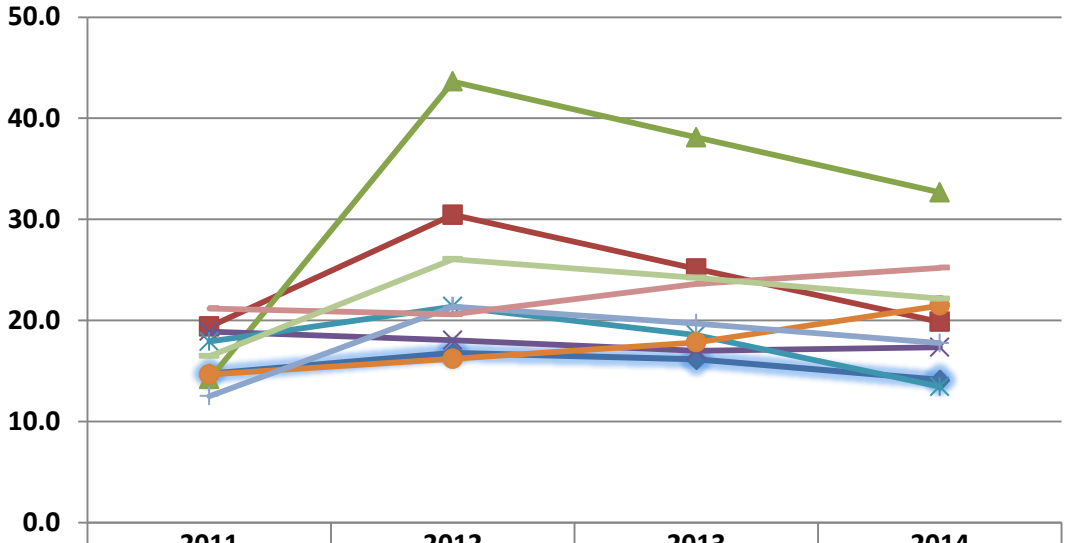
Figure 35. Number of overdose EMS responses per 10,000 residents, by Public Health District and primary type of substance involved: 2014



	Drug/Medication	Alcohol
Aroostook	14.1	16.0
Central	19.9	17.5
Cumberland	32.7	13.9
Downeast	17.3	15.8
Midcoast	13.5	9.5
Penquis	21.5	34.1
Western	17.7	8.1
York	25.2	19.0
Maine	22.2	16.6

Source: Emergency Medical Services, 2012

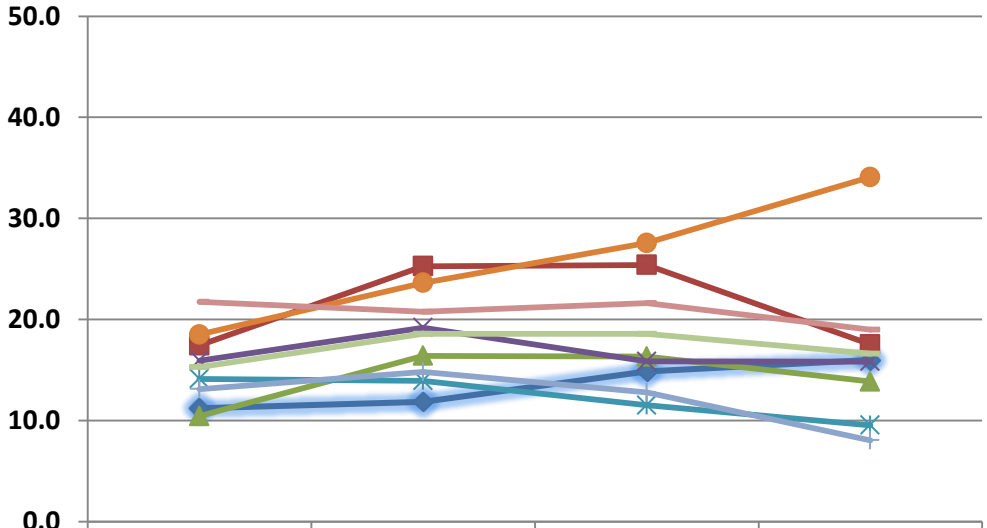
Figure 36. Number of overdose EMS responses due to drug/medication per 10,000 residents, by Public Health District: 2011-2014



	2011	2012	2013	2014
Aroostook	14.7	16.8	16.1	14.1
Central	19.4	30.4	25.1	19.9
Cumber.	14.2	43.6	38.1	32.7
Downeast	18.9	18.0	17.0	17.3
Midcoast	17.9	21.4	18.6	13.5
Penquis	14.7	16.2	17.8	21.5
Western	12.5	21.4	19.7	17.7
York	21.2	20.6	23.6	25.2
Maine	16.5	26.1	24.2	22.2

Source: Emergency Medical Services, 2012

Figure 37. Number of total overdose EMS responses due to alcohol per 10,000 residents, by Public Health District: 2011-2014



	2011	2012	2013	2014
Aroostook	11.2	11.9	14.8	16.0
Central	17.4	25.3	25.4	17.5
Cumberland	10.4	16.4	16.3	13.9
Downeast	15.9	19.2	15.9	15.8
Midcoast	14.1	13.9	11.5	9.5
Penquis	18.5	23.6	27.6	34.1
Western	13.1	14.8	12.8	8.1
York	21.7	20.8	21.6	19.0
Maine	15.3	18.6	18.6	16.6

Source: Emergency Medical Services

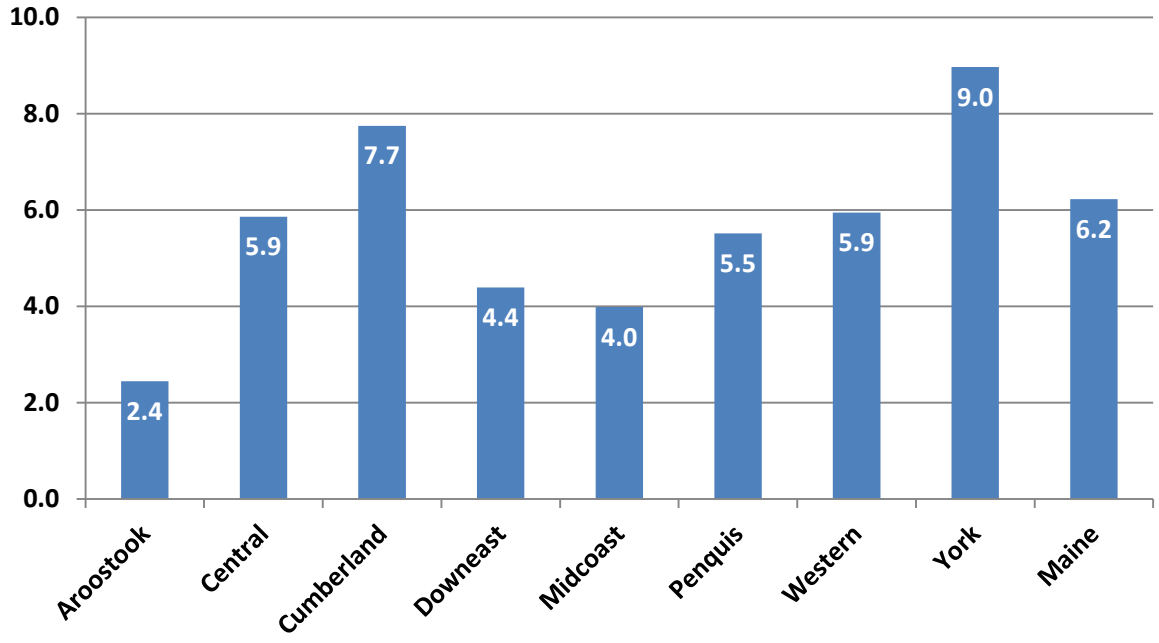
Indicator Description: NALOXONE ADMINISTRATIONS. This indicator shows the number of persons receiving naloxone administrations from Emergency Medical Services (EMS) related to an opioid overdose. Naloxone is a medication administered to patients who have experienced an overdose related to an opioid (*e.g.*, prescription painkillers, heroin, and morphine). This indicator includes instances where the opioid overdose is accidental (that is, not a result of intentional or recreational misuse).

Why Indicator is Important: Overdosing on a substance can cause serious physical harm resulting in hospitalization and even death. Responding to overdoses also uses valuable EMS resources. Furthermore, it is worth stating that this indicator gives us a better sense of the prevalence of opioid overdoses since it includes those that did not result in death.

Data Source(s): Emergency Medical Services, 2014

Summary: In 2014, Aroostook observed a rate of 2.4 naloxone administrations per 10,000 residents via overdose ambulance responses; this was the lowest rate among public health districts. Although not shown, naloxone was administered by EMS responders a total of 17 times in 2014.

Figure 38. Naloxone* administrations per 10,000 residents, by Public Health District: 2014



Source: Emergency Medical Services
**Naloxone is a medication administered to counter the effects of an overdose due to opioids.*

Indicator Description: DEATHS DUE TO OVERDOSE. This measure reflects the number of deaths where the cause of death was directly related to the consumption of one or more substances. The measure excludes deaths where a substance may have been ingested prior to engaging in a behavior that resulted in death (e.g., drunk driving) or where lifetime substance use and abuse may have impacted health (e.g., cirrhosis). In order to preserve anonymity and strengthen validity, rates were calculated based on the sum of deaths per three year intervals. The rate per 100,000 allows us to see the frequency with which an occurrence happens within a population over time, as well as make relative comparisons between small and large population areas. In this case, the base of 100,000 people was used due to small numbers.

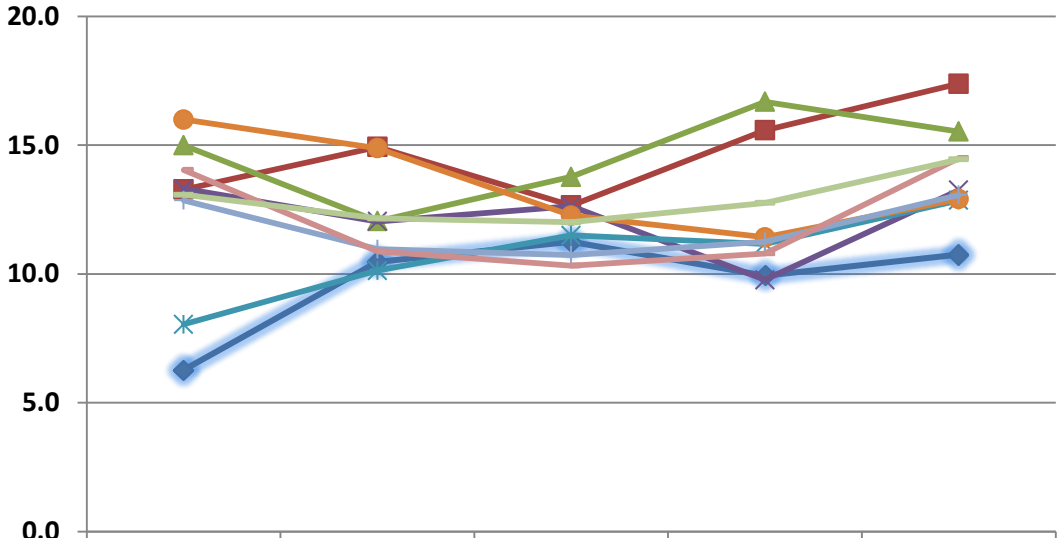
Operationalized as: $\left(\frac{\#\ of\ overdose\ deaths}{population}\right) \times 100{,}000$

Why Indicator is Important: One of the most extreme consequences of alcohol and drug abuse is overdose death; that is, the substance(s) consumed played a direct role in an individual's death. These are seen as potentially preventable deaths.

Data Source(s): Marci Sorg, Margaret Chase Smith Policy Center at University of Maine, Office of the Chief Medical Examiner, 2009-10 to 2013-14.

Summary: During 2013-14 (combined years), Aroostook observed an average of 10.8 drug related overdose deaths per 100,000 residents; this was the lowest rate among public health districts. Aroostook has consistently observed some of the lowest rates since 2009-10.

Figure 39. Drug-related death rate per 100,000, by Public Health District: 2009-10 to 2013-14



	2009-10	2010-11	2011-12	2012-13	2013-14
Aroostook	6.3	10.5	11.2	9.9	10.8
Central	13.3	14.9	12.7	15.6	17.4
Cumberland	15.0	12.0	13.8	16.7	15.5
Downeast	13.3	12.0	12.6	9.8	13.3
Midcoast	8.0	10.1	11.5	11.2	12.9
Penquis	16.0	14.9	12.3	11.4	12.9
Western	12.9	11.0	10.7	11.3	13.1
York	14.0	10.9	10.3	10.8	14.5
Maine	13.1	12.2	12.0	12.8	14.4

Source: Marci Sorg, Margaret Chase Smith Policy Center at University of Maine, Office of the Chief Medical Examiner

Factors Contributing to Substance Use and Abuse

A body of substance abuse prevention research has identified certain groups of factors that "cause" or have an impact on substance use and the consequences related to use. That is, they appear to influence the occurrence and magnitude of substance use and its related consequences. Generically, these causal factors (also known as contributing factors) are categorized into groups which include:

- Social Access (e.g., getting drugs and alcohol from friends or family)
- Retail Availability (e.g., retailer not carding properly)
- Pricing & Promotion (e.g., two-for-one specials, industry sponsorships or signage)
- Social/Community Norms (e.g., parental/community attitudes and beliefs)
- Enforcement (e.g., lack of compliance checks)
- Perceptions of Harm (e.g., individuals' belief that using a substance is harmful)[3]
- Perceived Risk of Being Caught (e.g., individuals' belief that s/he will be caught by parents or police)[4]

Substance abuse prevention in Maine is undertaken with the assumption that making changes to these factors at the community level will result in changing behaviors around substance use and related problems. It is through positively impacting these factors that Maine can achieve population-level changes in substance consumption and consequences.

Although most high school students in Aroostook seem to perceive that regular use of substances poses a risk of harm, rates of perception of harm from smoking marijuana among youth and adults have been declining rapidly in recent years. In addition, parental attitudes regarding their teen using marijuana have shifted to be more permissive, especially concerning medicinal marijuana use. Accessibility of substances to youth remains to be a challenge. In fact, two thirds of students in Aroostook think it is easy to obtain alcohol and about half felt marijuana would be easily accessible. In 2015, nearly four out of ten parents felt their teen could access alcohol in their house without their knowledge. Moreover, almost one in three parents felt prescription drugs could be accessed by their teen without them knowing.

[3] Bonnie, R. J & O'Connell, M.E., Eds. (2004). *Reducing Underage Drinking: A Collective Responsibility.* The National Academies Press: Washington, DC.

[4] Birckmayer, J. D., Holder, H. D., Yacoubian, Jr., G. S., & Friend, K. B. (2004). A general causal model to guide alcohol, tobacco, and illicit drug prevention: assessing the research evidence. *Journal of Drug Education*, *34*(2), 121-153.

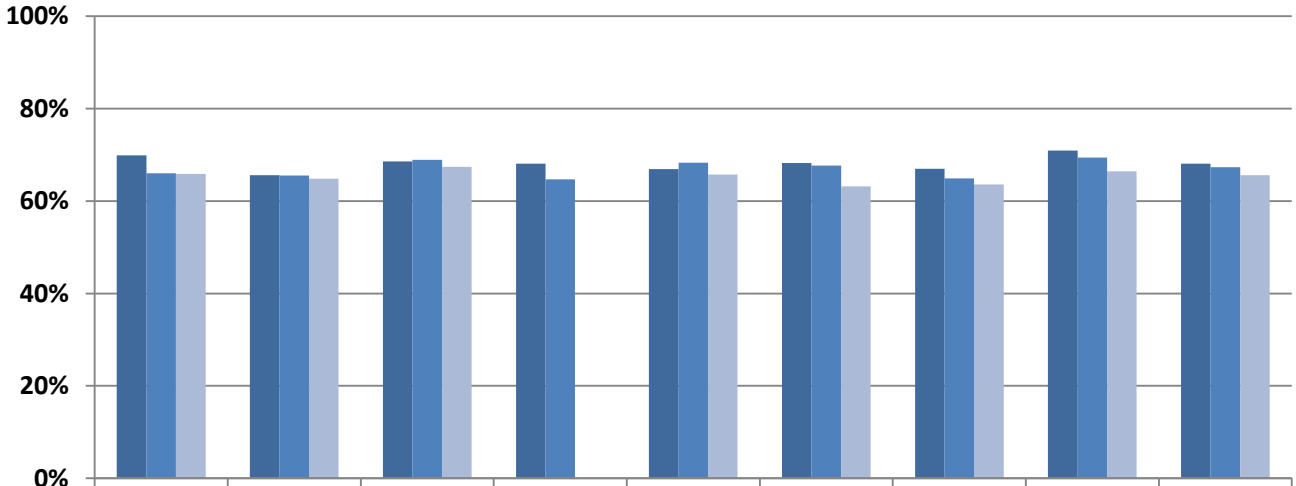
Indicator Description: PERCEIVED EASE OF OBTAINING ALCOHOL BY UNDERAGE YOUTH. This indicator reflects the percentage of high school students (grades 9 to 12) who reported that it would be easy or very easy for them to get alcohol if they wanted some.

Why Indicator is Important: In 2013, students who reported that they thought alcohol was easy to obtain were three times as likely to report consuming alcohol within the past month compared to students who did not think it was easy to obtain.

Data Source(s): MIYHS, 2009-2013.

Summary: From 2009 to 2013, the percentage of high school students in Aroostook who indicated that it was easy to get alcohol decreased from 70 percent to 66 percent. This was same as the statewide rate of 67 percent.

Figure 40. Percent of high school students by Public Health District who reported it was easy to get alcohol: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	70%	66%	69%	68%	67%	68%	67%	71%	68%
2011	66%	66%	69%	65%	68%	68%	65%	69%	67%
2013	66%	65%	67%		66%	63%	64%	66%	66%

Source: MIYHS

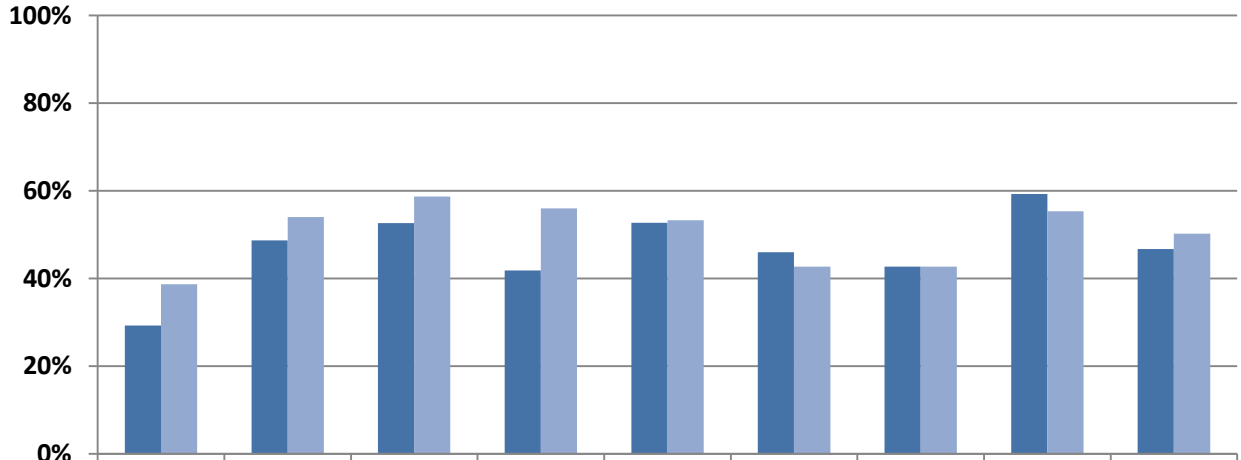
Indicator Description: PARENT PERCEPTION OF ACCESSIBILITY OF ALCOHOL AT HOME. This indicator measures the percentage of parents reporting that their teen would be able to access alcohol they had purchased without their knowledge. This data comes from the Maine Parent Survey administered by Pan Atlantic for the Maine Office of Substance of Abuse and Mental Health Services.

Why Indicator is Important: Easy access to alcohol at home is a major contributing factor to underage drinking.

Data Source(s): Parent Survey 2013 and 2015

Summary: In 2015, among parents of middle and high school youth, 39 percent felt it was possible for their children to access alcohol they had purchased without their knowledge; this was 11 percentage points lower than the statewide average and lowest among public health districts. Aroostook's rate did increase by ten percentage points since 2013 (29%).

Figure 41. Parent perception of accessibility of parent purchased alcohol without parental knowledge: 2013 and 2015



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	29%	49%	53%	42%	53%	46%	43%	59%	47%
2015	39%	54%	59%	56%	53%	43%	43%	55%	50%

Source: Parent Survey

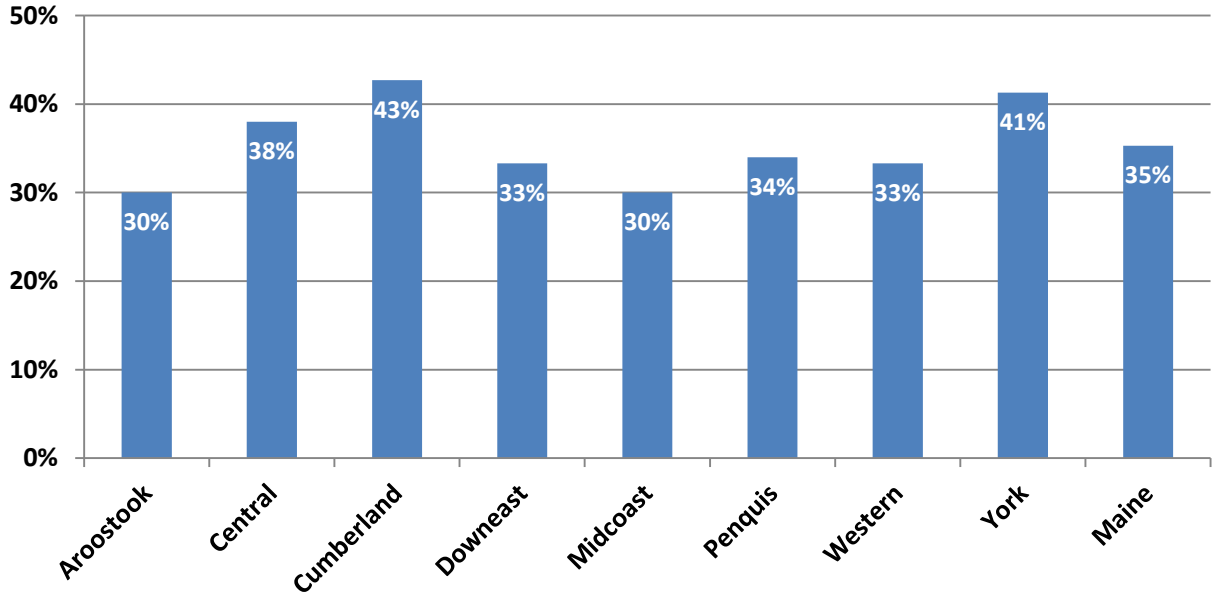
Indicator Description: PARENT PERCEPTION OF ACCESSIBILITY OF RX DRUGS AT HOME. This indicator measures the percentage of parents reporting that their teen would be able to access prescription medication (not prescribed to their child) without their knowledge. This question was first asked in 2015 Parent Survey. This data comes from the Maine Parent Survey administered by Pan Atlantic for the Maine Office of Substance of Abuse and Mental Health Services.

Why Indicator is Important: Easy access to prescription drugs at home is a major contributing factor to prescription drug misuse.

Data Source(s): Parent Survey 2015

Summary: Almost a third (30%) of Aroostook parents felt that, at home, their child would be able to access prescription medications that were not prescribed to the child, without their parents' knowledge. Aroostook's rate was five percentage points lower than the statewide average and among the lowest across public health districts.

Figure 42. Parent perception of teen accessibility of prescription drugs at home without parental knowledge: 2015



Source: Parent Survey

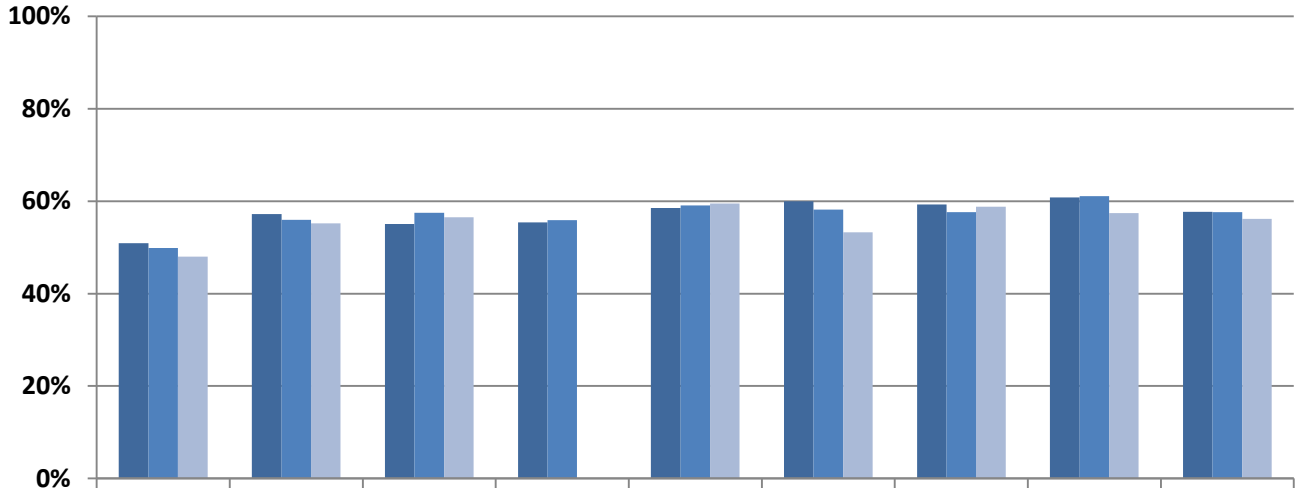
Indicator Description: PERCEIVED EASE OF OBTAINING MARIJUANA BY YOUTH. This indicator illustrates the percentage of high school students reporting it would be easy or very easy to obtain marijuana if they wanted it.

Why Indicator is Important: In 2013, students who reported that they thought marijuana was easy to obtain were nearly eight times as likely to use marijuana in the past 30 days compared to their peers who thought it was difficult to obtain.

Data Source(s): MIYHS, 2009-2013.

Summary: In 2013, 48 percent of high school students in Aroostook indicated that it would be easy to get marijuana; the state average was notably higher (56%).

Figure 43. Percent of high school students by Public Health District who reported it would be easy to get marijuana: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	51%	57%	55%	55%	59%	60%	59%	61%	58%
2011	50%	56%	58%	56%	59%	58%	58%	61%	58%
2013	48%	55%	57%		60%	53%	59%	57%	56%

Source: MIYHS

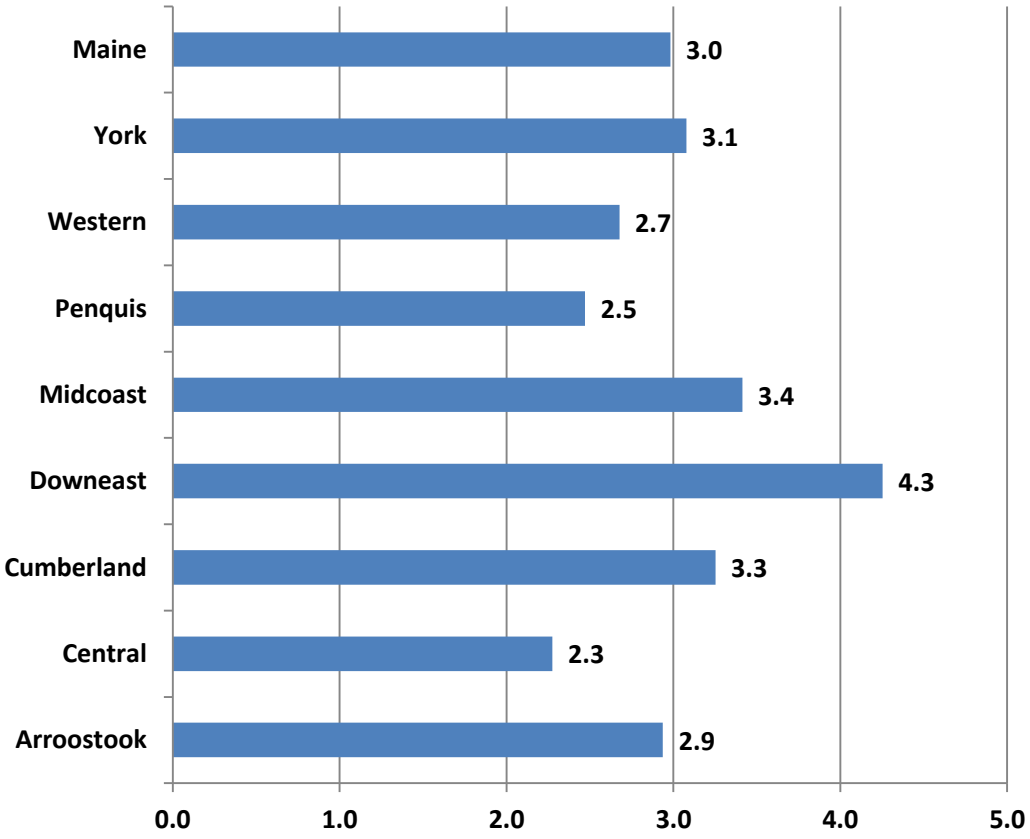
Indicator Description: NUMBER OF ALCOHOL OUTLETS PER CAPITA. This indicator reflects the number of active (as of June 2015) retail establishments selling alcohol per person. This includes both on-premise (e.g., bars, restaurants) and off-premise (e.g., convenience stores) establishments. It is calculated by dividing the number of retail establishments by the number of residents in the county (based on 2014 U.S. Census estimates).

Why Indicator is Important: National research shows that there is a correlation between the number of places that sell alcohol in an area (retail density) and the rate of alcohol-related crime.[5]

Data Source(s): DPS, Liquor Licensing and Compliance, 2015; U.S. Census, 2014.

Summary: In 2015, the number of active liquor licensees in Aroostook per 1,000 residents (2.9) was slightly lower than the statewide average (3.0). Although not shown, as of June of 2015, Aroostook had 204 active liquor licensees.

Figure 44. Number of liquor licensees per 1,000 residents, by Public Health District: 2015



Source: DPS/U.S. Census

[5] Grube, J. W., Gruenewald, P. J. & Chen, M. J. (2010). Community alcohol outlet density and underage drinking. *Addiction*, *105*, 270-278.

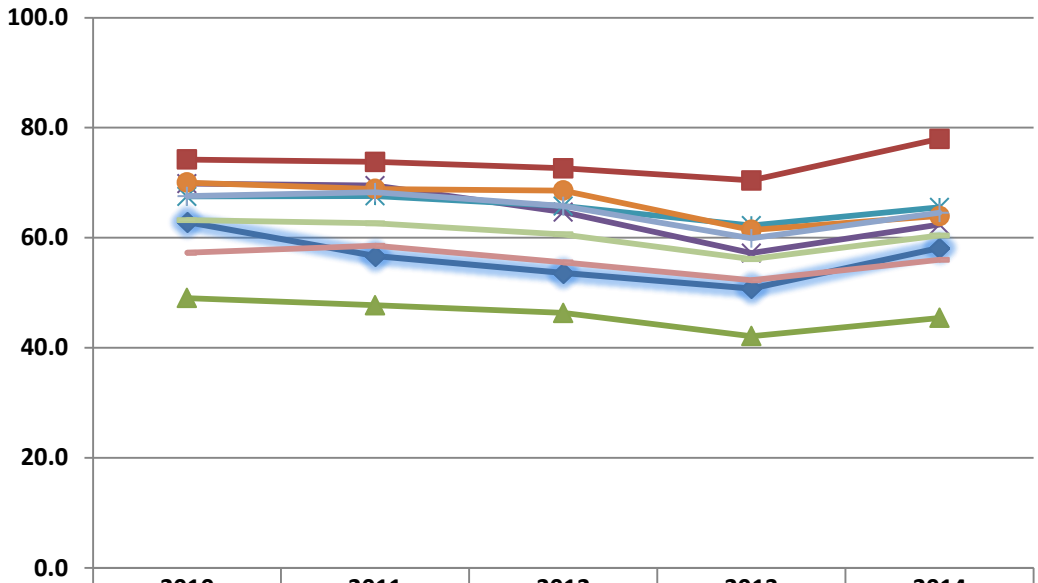
Indicator Description: DISPENSED QUANTITY OF SCHEDULE II DRUGS PER CAPITA. These indicators reflect the dispensed quantity of narcotics, tranquilizers, and stimulants through prescriptions in Maine. This includes only prescription drugs that are classified "Schedule II" drugs, meaning those with a higher potential for abuse and addiction. It is important to note that the dispensed quantity does not indicate the size or dosage of the pills associated with the prescription. All pharmacies in Maine report to the Prescription Monitoring Program.

Why Indicator is Important: The dispensed quantity per capita indicates the volume of prescription drugs potentially available in the community for diversion (e.g., gift, sale, or theft). A higher level of availability contributes to misuse by individuals without a prescription.

Data Source(s): PMP, 2010-2014

Summary: In 2014, the rate of dispensed quantity of narcotics per capita in Aroostook was the second lowest among public health districts (58.2 pills per person); this was slightly lower than the statewide rate of 60.4 narcotic pills per person. In 2014, as with all public health districts, Aroostook observed an uptick in the rate of narcotics dispensed per capita. This increase was most likely due to the changes in data collection and drug classification (see note below chart).

Figure 45. Dispensed quantity of narcotics per capita, by Public Health District: 2010-2014*



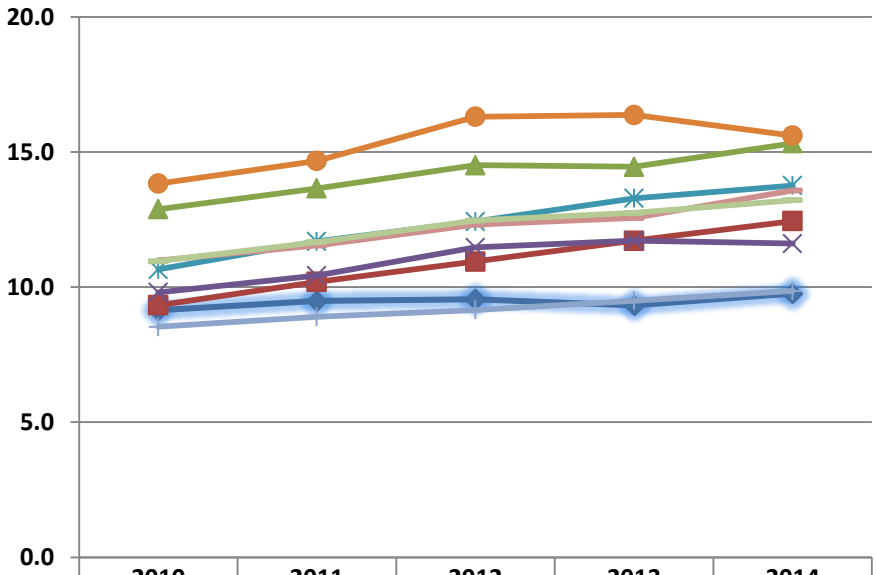
	2010	2011	2012	2013	2014
Aroostook	62.9	56.7	53.6	50.8	58.2
Central	74.2	73.8	72.6	70.4	78.0
Cumberland	49.0	47.7	46.3	42.1	45.4
Downeast	69.8	69.5	64.6	57.2	62.4
Midcoast	67.5	67.6	65.8	62.2	65.5
Penquis	70.0	68.9	68.6	61.4	64.0
Western	67.5	68.3	65.8	59.9	64.5
York	57.3	58.6	55.5	52.3	56.0
Maine	63.2	62.6	60.6	56.1	60.4

Source: PMP, 2010-2014

**The increase observed in 2014 in number of narcotic pills prescribed per capita was due in part to the inclusion of the previously unscheduled drug Tramadol (became a schedule II drug as of 8/18/2014) as well as the inclusion of data submitted via the Veterans Administration (as of 10/31/2014). Data shown only includes two months of VA data therefore rates are expected to increase in coming years.*

Summary: In 2014, the rate of the quantity of stimulants dispensed in Aroostook was 9.8 pills per person: this was the lowest rate among public health districts. For the past several years Aroostook's rate for dispensed stimulant pills per capita has remained relatively stable.

Figure 46. Dispensed quantity of stimulants per capita, by Public Health District: 2010-2014

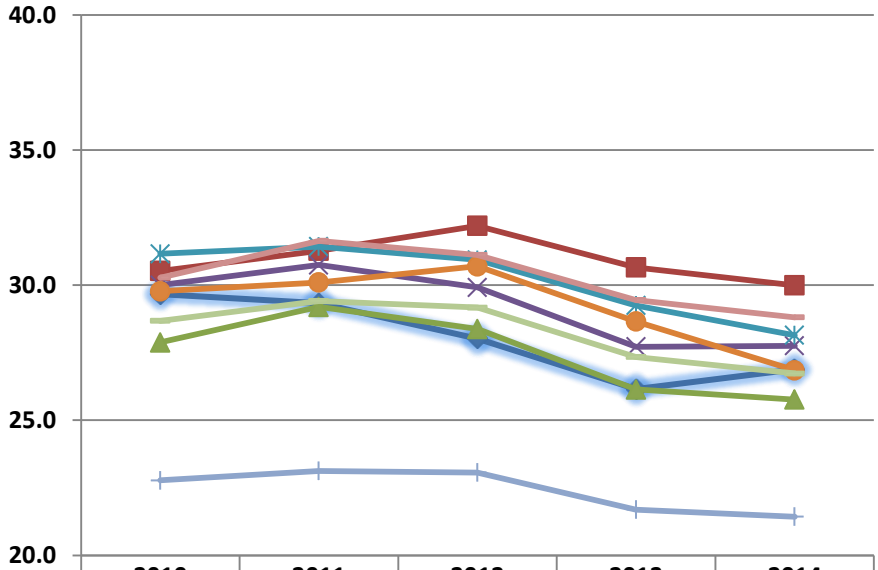


	2010	2011	2012	2013	2014
Aroostook	9.1	9.5	9.6	9.3	9.8
Central	9.3	10.2	10.9	11.7	12.4
Cumberland	12.9	13.6	14.5	14.5	15.3
Downeast	9.8	10.4	11.5	11.7	11.6
Midcoast	10.6	11.7	12.4	13.3	13.8
Penquis	13.8	14.7	16.3	16.4	15.6
Western	8.5	8.9	9.1	9.5	9.9
York	11.0	11.5	12.3	12.6	13.6
Maine	11.0	11.7	12.5	12.7	13.2

Source: PMP, 2010-2014

Summary: In 2014**,** the rate of the quantity of tranquilizers dispensed in Aroostook was 26.9 pills per person; this was on par with the statewide average (26.7 pills per person). As with all other public health districts, the dispensed quantity rate for tranquilizers has decreased slightly since 2012.

Figure 47. Dispensed quantity of tranquilizers per capita, by Public Health District: 2010-2014



	2010	2011	2012	2013	2014
Aroostook	29.7	29.3	28.0	26.2	26.9
Central	30.5	31.3	32.2	30.7	30.0
Cumberland	27.9	29.2	28.4	26.1	25.8
Downeast	30.0	30.7	29.9	27.7	27.8
Midcoast	31.2	31.4	30.9	29.2	28.1
Penquis	29.8	30.1	30.7	28.7	26.8
Western	22.8	23.1	23.1	21.7	21.4
York	30.3	31.6	31.1	29.4	28.8
Maine	28.7	29.4	29.2	27.3	26.7

Source: PMP, 2010-2014

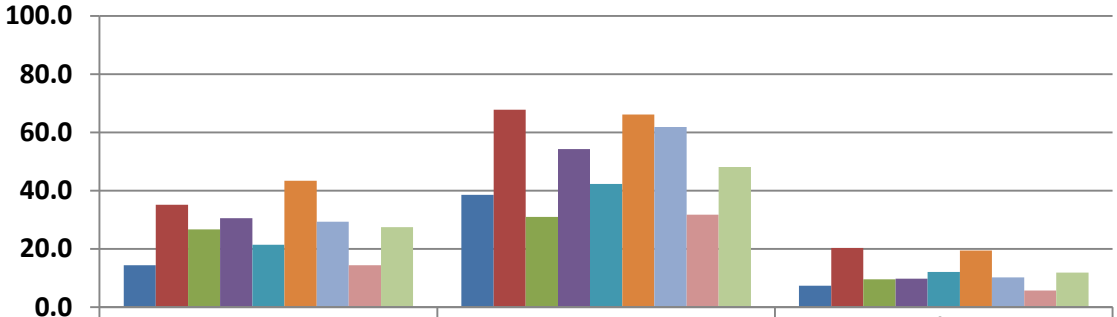
Indicator Description: SUBSTANCES REQUESTED FOR VERIFICATION. This indicator shows the rate of requests by non-law enforcement for medication verification through the Northern New England Poison Center. A person may call the NNEPC for many reasons, one being to help identify a medication or substance which another person has consumed or that has been found. The calls reflected in this indicator have been characterized by NNEPC as likely related to substance abuse, although NNEPC staffs do not make a formal or clinical assessment.

Why Indicator is Important: The increased volume of medication verification calls suggests a greater availability of those drugs in the community. This measure also suggests that there is a higher awareness among the community and parents for potential misuse of prescription pills which is prompting calls.

Data Source(s): NNEPC, 2013-14

Summary: During the period of 2013-14**,** most calls to NNEPC within Aroostook requesting substance verification involved opioids (38.6 calls per 10,000 residents), followed by benzodiazepines (14.3 calls per 10,000 residents), and stimulants (7.3 calls per 10,000 residents). These rates were lower than those statewide. Although not shown, calls throughout the state requesting substance verification have been decreasing steadily within all drug types across public health districts for the past several years.

Figure 48. Number of poisonings reported to New England Poison Center per 10,000 residents, by drug type and Public Health District: 2013-14



	Benzodiazepines	Opioids	Stimulants/street drugs
Aroostook	14.3	38.6	7.3
Central	35.1	67.7	20.3
Cumber.	26.7	31.0	9.6
Downeast	30.5	54.3	9.8
Midcoast	21.5	42.3	12.1
Penquis	43.4	66.2	19.5
Western	29.4	61.8	10.2
York	14.3	31.7	5.6
Maine	27.5	48.1	11.9

Source: NNEPC

Perceived Risk and Harm

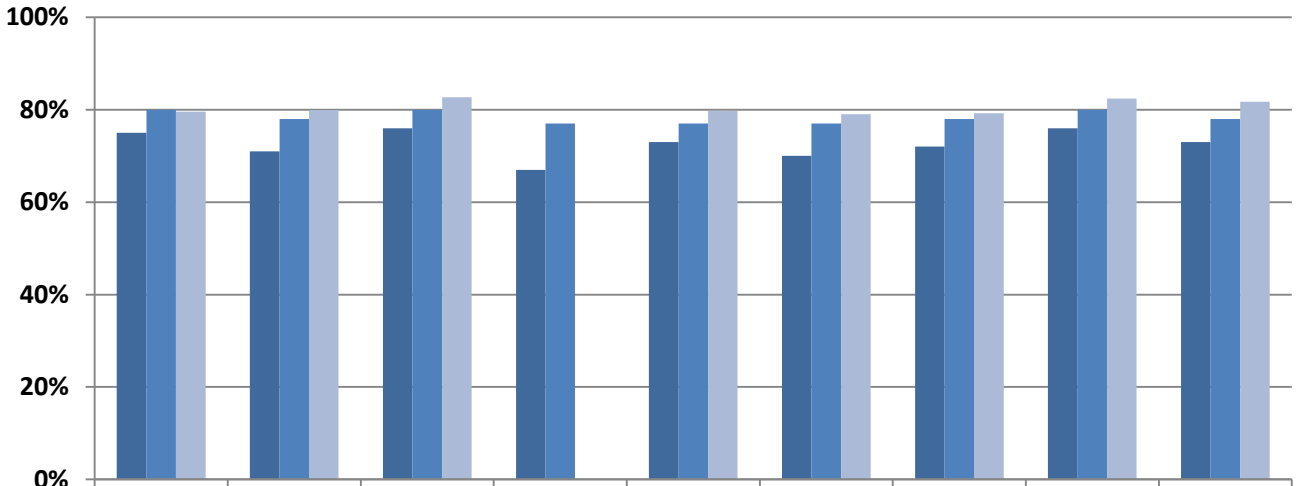
Indicator Description: PERCEIVED RISK FROM BINGE DRINKING AMONG YOUTH. This indicator reflects the percentage of individuals who perceive that there is moderate-to-great risk from drinking five or more drinks once or twice per week.

Why Indicator is Important: In 2013, High school students who did not perceive a moderate to great risk of harm from binge drinking once or twice a week were more than twice as likely to drink in the past month as high school students who did perceive risk of harm. Perceptions around the risks of binge drinking are related to high-risk alcohol use among adults as well.

Data Source(s): MIYHS, 2009-2013.

Summary: From 2009 to 2013, the percentage of high school students in Aroostook who indicated that there is a moderate-to-great risk of people harming themselves if they consume five or more drinks regularly increased from 75 percent to 80 percent. This is slightly lower than the state average (82%).

Figure 49. Percent of high school students by Public Health District who reported a risk of harm from consuming five or more drinks once or twice per week: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	75%	71%	76%	67%	73%	70%	72%	76%	73%
2011	80%	78%	80%	77%	77%	77%	78%	80%	78%
2013	80%	80%	83%		80%	79%	79%	82%	82%

Source: MIYHS

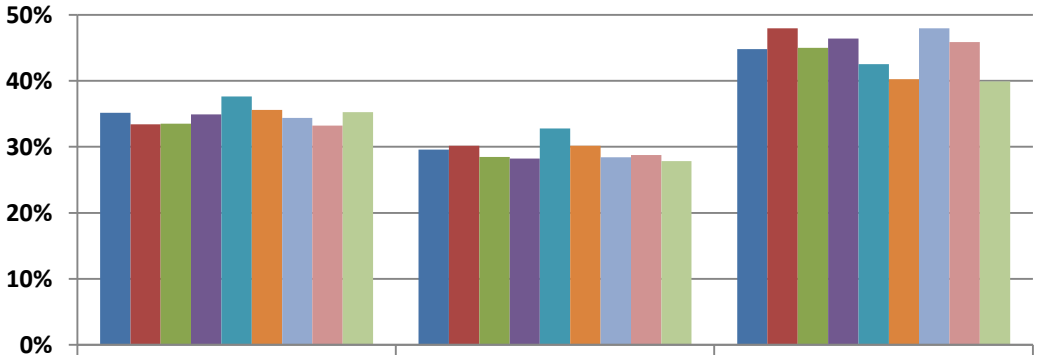
Indicator Description: PERCEIVED RISK FROM BINGE DRINKING AMONG MAINERS. This indicator reflects the percentage of Mainers age 18 and older who perceive that there is risk from consuming five or more drinks once or twice per week. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

Why Indicator is Important: The perception that consuming a lot of alcohol is risky indicates an individual is knowledgeable about health risks and other negative consequences. Adults are less likely to binge drink if they perceive it to be risky.

Data Source(s): NSDUH, 2010-12.

Summary: During the period 2010-12, Aroostook/Downeast PHD[6] residents ages 18-25 indicated the lowest perception of risk from binge drinking among age groups within the district at 30 percent, while those 26 and older had the highest proportion (40%). Aroostook/Downeast's rates of perception are very similar to those of the state. Although not shown, rates of perception of risk from binge drinking among Aroostook/Downeast residents 12 and older have remained relatively unchanged for the past several years.

Figure 50. Percent of population age 12 or older who perceive a great risk from binge drinking, by Public Health District: 2010-12



	12 to 17	18 to 25	26+
Maine	35%	30%	45%
Aroostook	33%	30%	48%
Downeast	33%	28%	45%
Central	35%	28%	46%
Cumber.	38%	33%	43%
Midcoast	36%	30%	40%
Penquis	34%	28%	48%
Western	33%	29%	46%
York	35%	28%	40%

Source: NSDUH

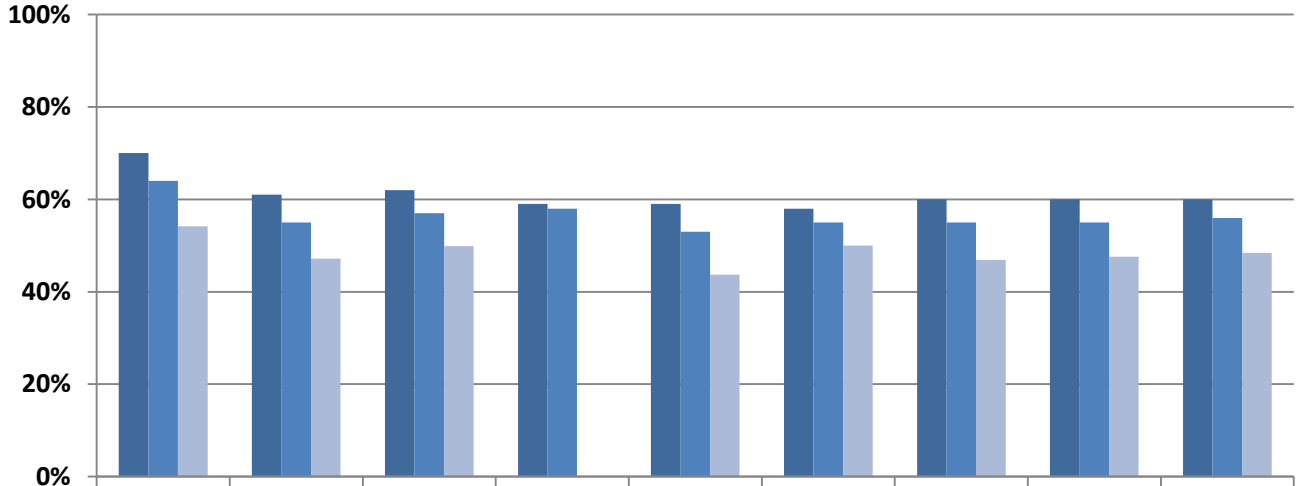
Indicator Description: PERCEIVED RISK OF REGULAR MARIJUANA USE AMONG YOUTH. This measure demonstrates the percentage of individuals who perceive a moderate-to-great risk of harm from smoking marijuana regularly.

Why Indicator is Important: High school students who do not believe there is moderate to great risk in smoking marijuana regularly are almost eight times as likely to smoke marijuana as their peers who do perceive risk of harm. A similar relationship exists between adult perceptions and consumption.

Data Source(s): MIYHS, 2009-2013.

Summary: From 2009 to 2013, the percentage of high school students in Aroostook who indicated that there is a moderate-to-great risk of people harming themselves if they smoke marijuana regularly decreased dramatically from 70 percent to 54 percent. The percentage of Aroostook high school students holding this view was significantly greater than the state average (48%).

Figure 51. Percent of high school students by Public Health District who reported a risk of harm from smoking marijuana regularly: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	70%	61%	62%	59%	59%	58%	60%	60%	60%
2011	64%	55%	57%	58%	53%	55%	55%	55%	56%
2013	54%	47%	50%		44%	50%	47%	48%	48%

Source: MIYHS

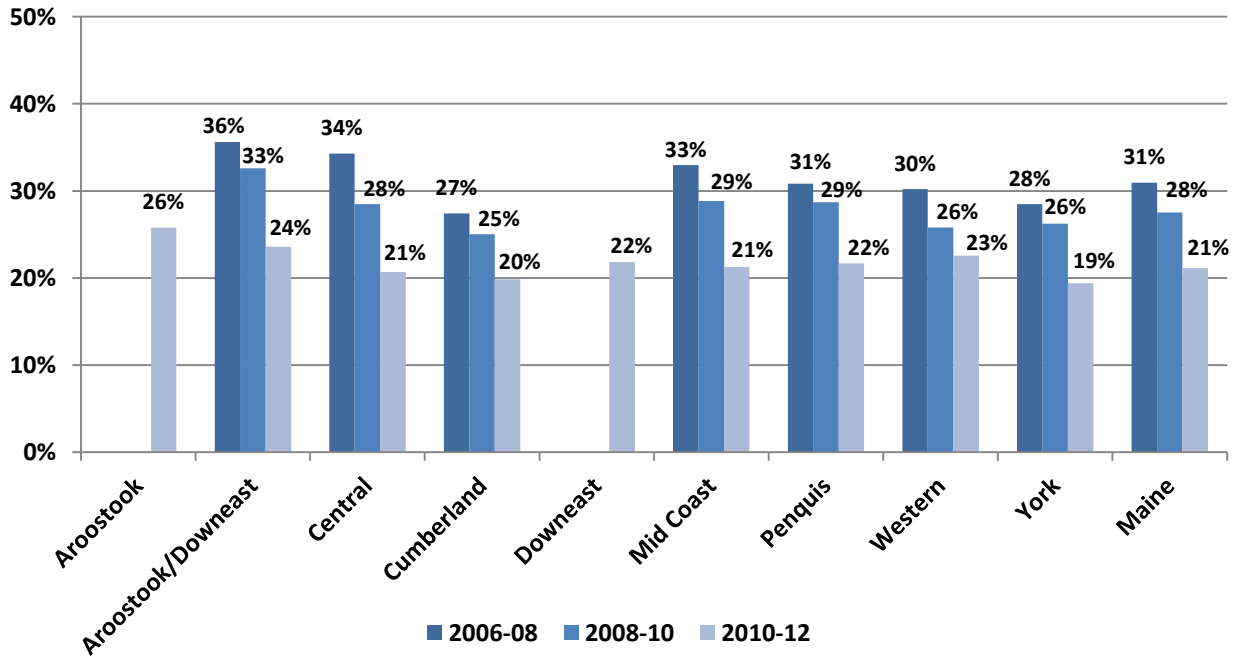
Indicator Description: PERCEIVED RISK OF MARIJUANA USE AMONG MAINERS. This measure demonstrates the percentage of Mainers over the age of 12 who perceive a risk of harm from smoking marijuana once a month. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

Why Indicator is Important: The perception that using a substance is risky indicates an individual is knowledgeable about health risks and other negative consequences associated with that substance. Perceptions of risk reduce the likelihood that an individual will engage in the behavior.

Data Source(s): NSDUH, 2006-08 to 2010-12.

Summary: From 2006-08 to 2008-10, the percentage of Aroostook and Downeast PHD[7] residents 12 and older who perceived a great risk from smoking marijuana once a month decreased from 36 percent to 33 percent. Aroostook/Downeast had the highest perception of risk among public health districts in 2008-10.

Figure 52. Percent of population age 12 or older who perceive a great risk from smoking marijuana once a month by Public Health District: 2006-2008 to 2010-12*



Source: NSDUH
**Estimates for Aroostook and Downeast (as single entities) are not available for 2006-08 and 2008-10. Years prior to 2010-12 combine Aroostook and Downeast public health districts.*

[7] Due to small sample sizes, Aroostook and Downeast Public Health District (which consists of Washington County and Hancock County) were combined to produce this estimate.

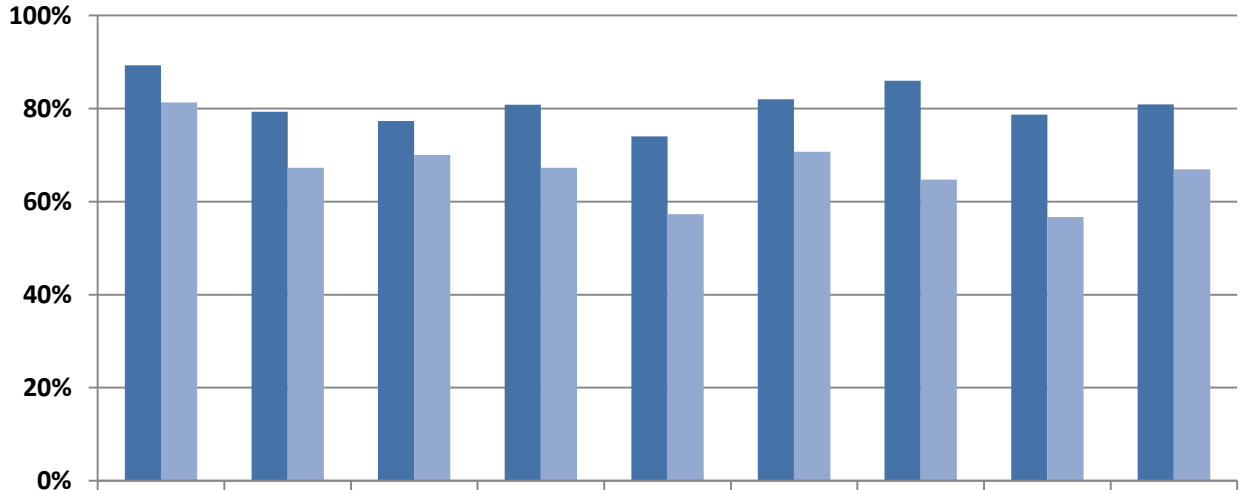
Indicator Description: PARENTAL ATTITUDES REGARDING MARIJUANA USE. This indicator reflects how parents felt about their teen using marijuana. Maine parents of teenagers (7th thru 12th graders) were asked to select the response that best described their attitude about marijuana use by their child. Response options were mutually exclusive.

Why Indicator is Important: Parental perceptions and permissive attitudes towards substance use can have a major effect in their child's decision to use. As Maine observes changes in regulations and policies regarding marijuana use; cultural norms and beliefs around use are occurring as well.

Data Source(s): Parent Survey, 2013 and 2015

Summary: In 2015, eight out of ten (81%) parents in Aroostook felt it was never okay for their teen to use marijuana; this was substantially higher the statewide rate (67%). The rate of disapproval among parents concerning teen marijuana use dropped by 8 percentage points since 2013 (89%).

Figure 53. Parental disapproval regarding their teen using marijuana: 2013 and 2015



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2013	89%	79%	77%	81%	74%	82%	86%	79%	81%
2015	81%	67%	70%	67%	57%	71%	65%	57%	67%

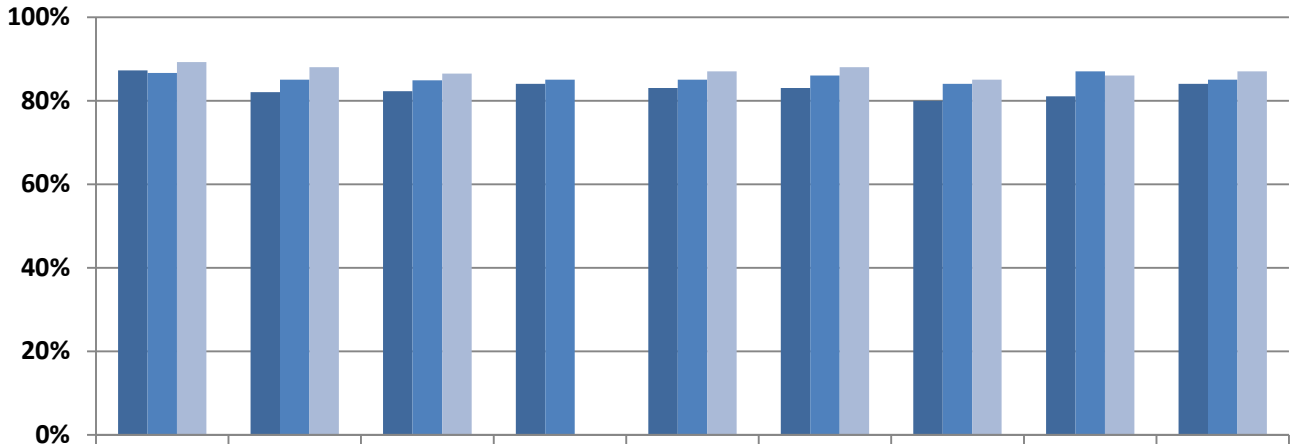
Indicator Description: PERCEIVED RISK OF PRESCRIPTION DRUG MISUSE AMONG YOUTH. This measure demonstrates the percentage of individuals who perceive a moderate-to-great risk of harm from taking a prescription drug that was not prescribed to them.

Why Indicator is Important: According to the 2013 statewide MIYHS, high school students who do not believe there is moderate-to-great risk misusing prescription drugs are 4.6 times as likely to smoke marijuana as their peers who do perceive risk of harm.

Data Source(s): MIYHS, 2009-2013.

Summary: Perception of risk from misusing prescription drugs among high school students in Aroostook increased slightly from 2009 (87%) to 2013 (89%). That means that about one in ten (11%) high school students in Aroostook did not think misusing prescription drugs was risky.

Figure 54. Percent of high school students who reported a risk of harm from misusing prescription drugs, by Public Health District: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	87%	82%	82%	84%	83%	83%	80%	81%	84%
2011	87%	85%	85%	85%	85%	86%	84%	87%	85%
2013	89%	88%	87%		87%	88%	85%	86%	87%

Source: MIYHS

Perceived Enforcement

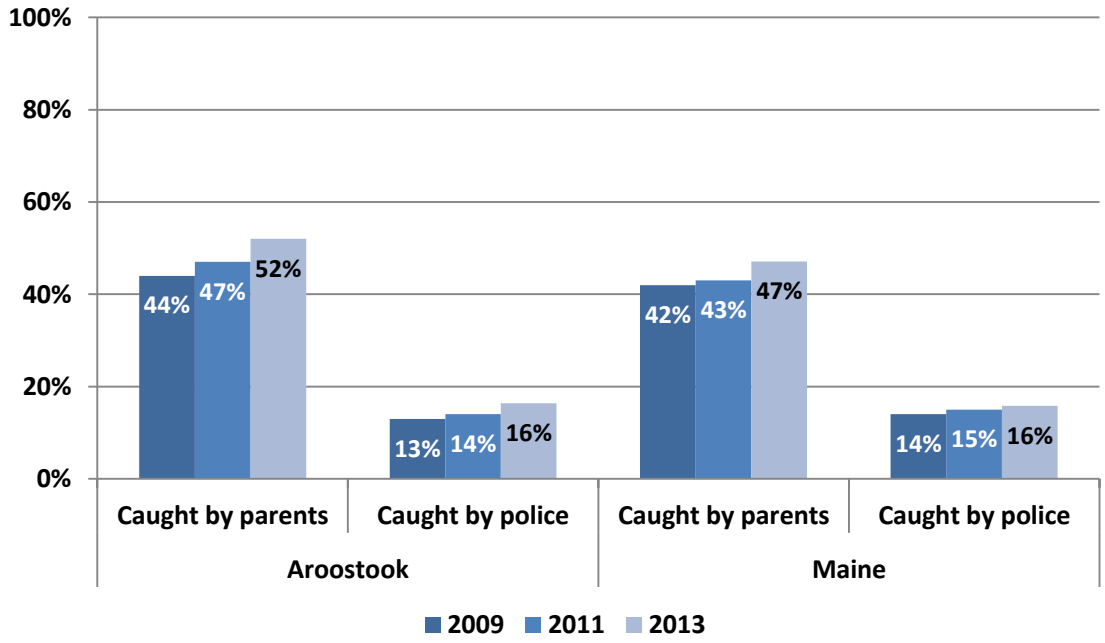
Indicator Description: PERCIEVED RISK OF BEING CAUGHT FOR DRINKING ALCOHOL AMONG YOUTH. This indicator reflects the percentage of high school students who reported that they would be caught by their parents or by police if they drank alcohol.

Why Indicator is important: According to the 2013 statewide MIYHS, high school students who believe they would not be caught by their parents are five times as likely to drink in the past month as compared to students who do think they will be caught. Students who believe that they would not be caught by the police are twice as likely to drink alcohol in the past month as those who do think they would be caught.

Data Source(s): MIYHS, 2009-2013.

Summary: At 52 percent, the perceived risk among high school students of being caught by their parents for drinking alcohol in Aroostook is greater than the state average (47%). Only 16 percent of high school students in Aroostook indicated that they thought they would be caught by the police for drinking alcohol (same as state average). That means high school students in Aroostook are more than three times as likely to perceive a risk of being caught by their parents, rather than the police, for drinking alcohol.

Figure 55. Perceived risk among high school students in Aroostook of being caught by parents or police for drinking alcohol: 2009-2013



Source: MIYHS

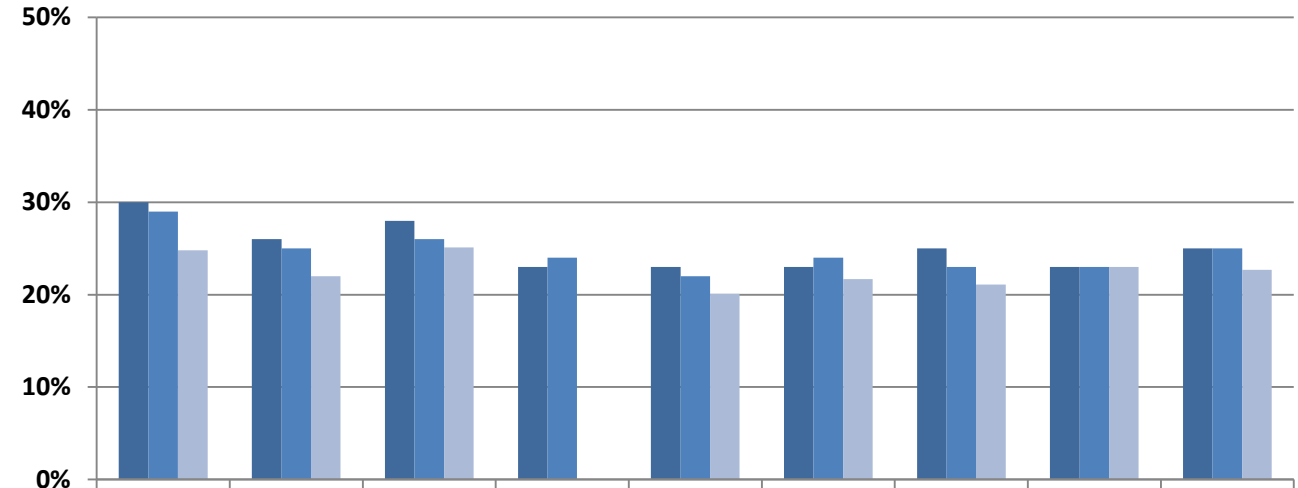
Indicator Description: PERCEIVED RISK OF BEING CAUGHT FOR SMOKING MARIJUANA AMONG YOUTH. This measure shows the percentage of high school students who reported that they thought they would be caught by police if they smoked marijuana.

Why Indicator is Important: According to the statewide 2013 MIYHS, high school students who believe they would be caught by the police are less than half as likely to smoke marijuana as their peers.

Data Source(s): MIYHS, 2009-2013.

Summary: The percent of high school students in Aroostook who indicated that they thought they would be caught by the police if they smoked marijuana fell by five percentage points from 2009 (30%) to 2013 (25%); this was slightly higher than the statewide rate (23%).

Figure 56. Perceived risk among high school students of being caught by police for smoking marijuana, by Public Health District: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	30%	26%	28%	23%	23%	23%	25%	23%	25%
2011	29%	25%	26%	24%	22%	24%	23%	23%	25%
2013	25%	22%	25%		20%	22%	21%	23%	23%

Source: MIYHS

Mental Health, Suicide and Co-occurring Disorders

The relationship between substance use and mental health has been well documented. There are great efforts underway at the Substance Abuse Mental Health Services Administration (SAMHSA) and throughout Maine to better integrate mental health promotion and substance abuse prevention. At the individual level, it is important to know if one exists because the symptoms of each can affect the other; that is, a person who is depressed may abuse alcohol or drugs in an effort to feel better. At the community level, it is important to understand how the prevalence of one interacts with the other so that prevention and intervention efforts can better address the needs of both. The data indicators included below represent the first attempt to collect multiple mental health indicators that can be routinely monitored in relation to substance abuse in hopes that this will lead to better prevention and intervention.

While rates of substance use tend to be lower in Aroostook, rates of mental health disorders and suicide/suicide ideation continue to be of concern. About one in four adults, as well as high school students, in Aroostook is challenged by depression or anxiety. Rates of anxiety among adults in Aroostook have been higher than those statewide in recent years. During the period 2013-14, Aroostook reported the highest rate of suicide deaths among public health districts; with 22.9 suicides per 100,000 residents. In 2013, one in seven high school students admitted to having seriously considered suicide in the past year. The rate of calls to the Poison Center that were suspected to be suicide attempts was among the highest across public health districts in 2014 and has been steadily increasing over the past several years.

Depression and Anxiety

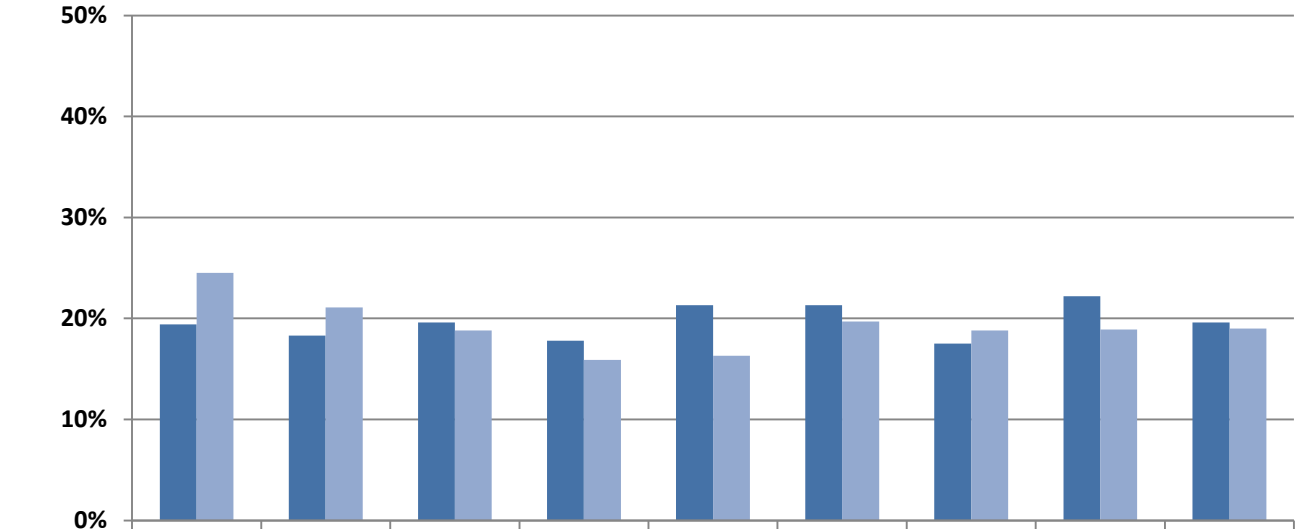
Indicator Description: DIAGNOSIS OF ANXIETY AND DEPRESSION AMONG ADULTS. This indicator examines the percentage of Maine residents age 18 and older who have ever been told by a doctor that they have a depressive or anxiety disorder.

Why Indicator is Important: The link between mental health and substance abuse is well documented. Experiencing anxiety or depression is associated with higher rates of substance abuse.

Data Source(s): BRFSS, 2011-12 and 2012-13.

Summary: The rate of adults in Aroostook reporting they have been diagnosed with an anxiety disorder increased by six percentage points from 2011-12 (19%) to 2012-13 (25%); this was higher than the 2012-13 statewide rate (19%) and highest among public health districts. Although not shown, in 2012-13, Aroostook females were more likely to report having been diagnosed with anxiety when compared to males (27% compared to 21%).

Figure 57. Percent of adults who have ever been told they have an anxiety disorder, by Public Health District: 2011-12 to 2012-13

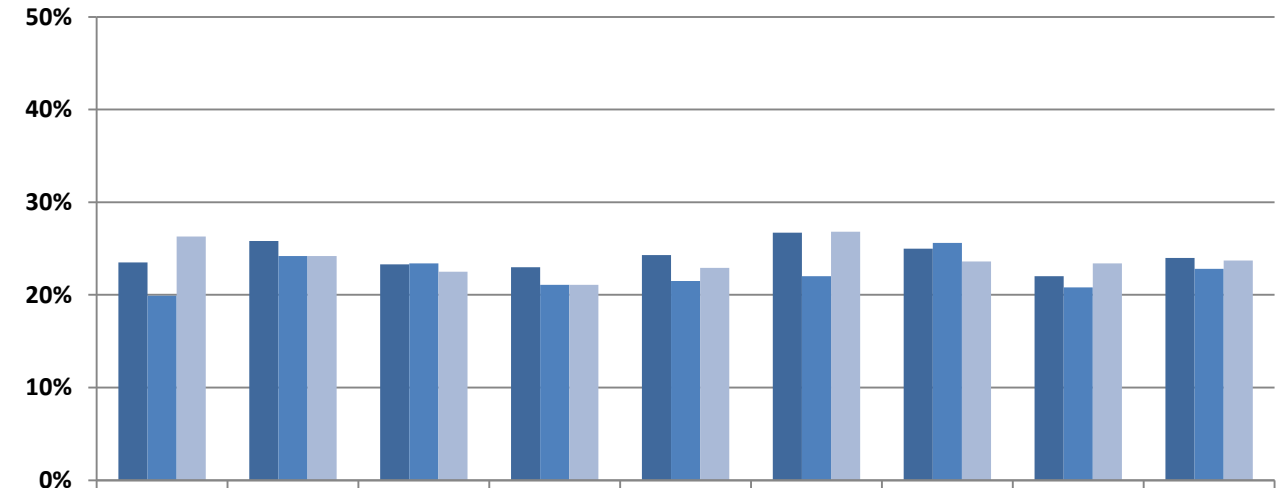


	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2011-12	19%	18%	20%	18%	21%	21%	18%	22%	20%
2012-13	25%	21%	19%	16%	16%	20%	19%	19%	19%

Source: BRFSS

Summary: The rate of Aroostook adults reporting they had been diagnosed with a depression disorder increased by two percentage points from 2011 (24%) to 2013 (26%); this was higher than the 2013 statewide rate of 24 percent.

Figure 58. Percent of adults who have ever been told they have a depression disorder, by Public Health District: 2011-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2011	24%	26%	23%	23%	24%	27%	25%	22%	24%
2012	20%	24%	23%	21%	22%	22%	26%	21%	23%
2013	26%	24%	23%	21%	23%	27%	24%	23%	24%

Source: BRFSS

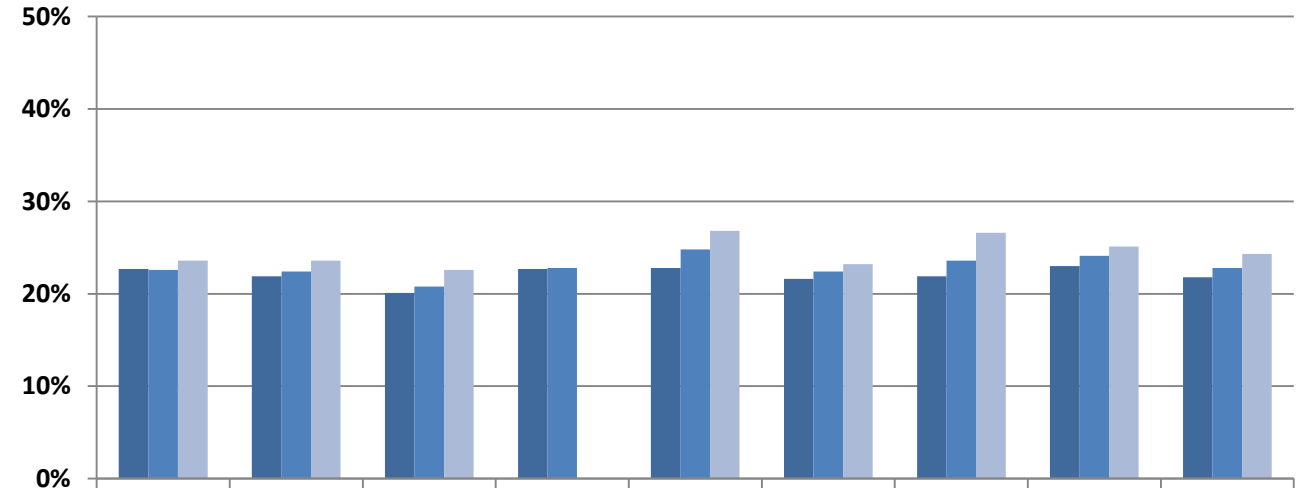
Indicator Description: DEPRESSION AMONG YOUTH. This indicator measures the percentage of high school students reporting they felt sad or hopeless almost every day for two weeks in a row during the past year.

Why Indicator is Important: Experiencing depression in the past year is associated with higher rates of substance abuse. According to the 2013 MIYHS, students who reported feeling hopeless or sad for at least two weeks within the past twelve months were almost twice as likely to have used marijuana or to have engaged in binge drinking in the past 30 days, and three times as likely to have misused prescription drugs during the past 30 days. Among youth, depression is also associated with problems with relationships and academic achievement.

Data Source(s): MIYHS, 2009-2013.

Summary: In 2013, 24 percent of high school students in Aroostook indicated that they felt sad or hopeless every day for two weeks or more in a row during the past year. This rate was the same found amongst Maine high school students overall.

Figure 59. Felt sad or hopeless almost every day for two weeks or more in a row during the past year, by Public Health District: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	23%	22%	20%	23%	23%	22%	22%	23%	22%
2011	23%	22%	21%	23%	25%	22%	24%	24%	23%
2013	24%	24%	23%		27%	23%	27%	25%	24%

Source: MIYHS

Suicide and Suicidal Ideation

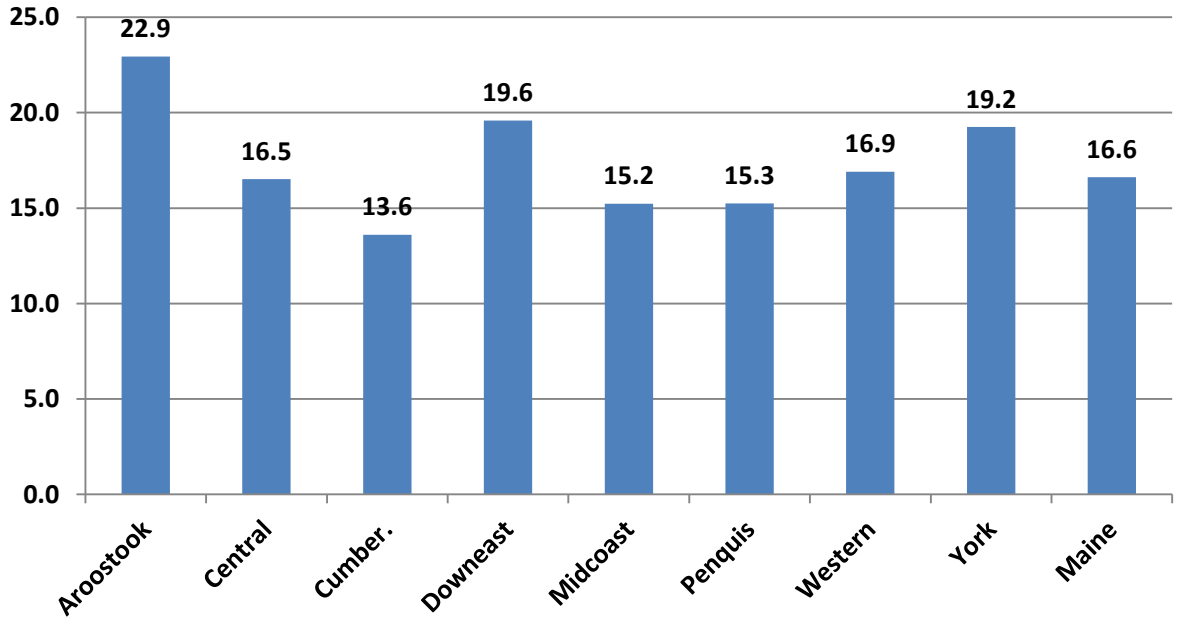
Indicator Description: RATE OF SUICIDE DEATHS. Every death in Maine has a recorded cause. This indicator examines deaths that were classified as a suicide. In this case, a rate per 100,000 of the state population is used to compare the prevalence across certain populations.

Why Indicator is Important: Although not the leading cause of death, substance use and abuse is often a factor in suicides. For example, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has estimated that 23 percent of suicides are attributable to alcohol nationally.

Data Source(s): ODRVS, 2013-14

Summary: During the two year period 2013-14, Aroostook reported a yearly average of 22.9 suicide deaths per 100,000 residents; this was the highest rate among public health districts. Although not shown, there were 16 suicide deaths in Aroostook in 2013 as well as 2014.

Figure 60. Number of suicide deaths per 100,000 residents, by Public Health District: 2013-14



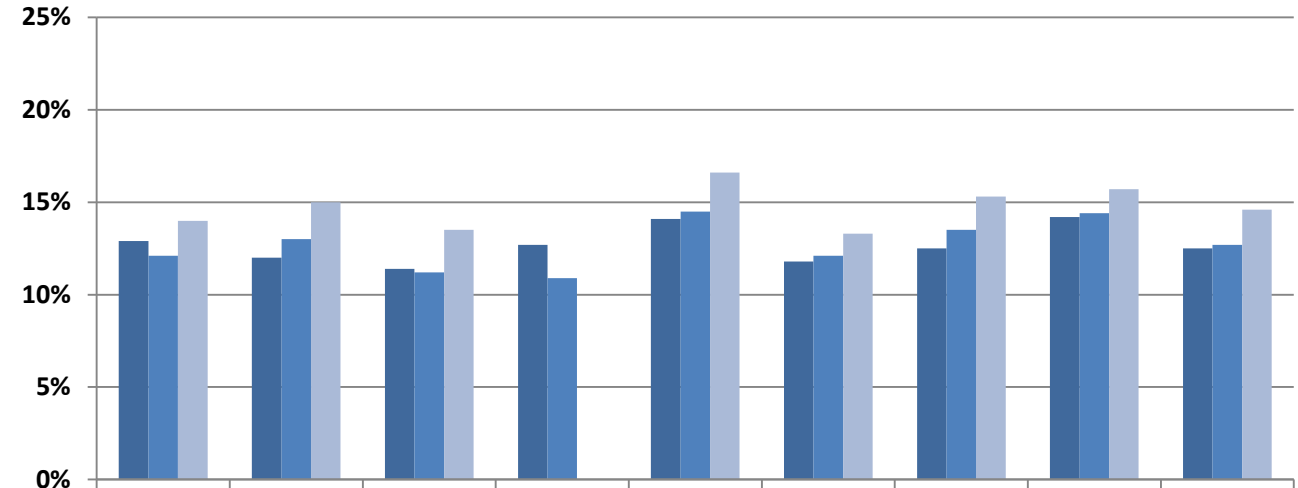
Indicator Description: SUICIDAL IDEATION AMONG YOUTH. This measure examines the percentage of high school students who reported that they seriously considered attempting suicide during the past year.

Why Indicator is Important: Suicide is the most tragic consequence of major depressive disorders. Abuse of alcohol or other drugs may increase emotional problems leading to suicidal ideation and suicidal behavior.

Data Source(s): MIYHS, 2009-2013.

Summary: In 2013 14 percent of high school students in Aroostook had considered suicide during the past year.

Figure 61. Percent of high school students who considered suicide during the past year, by Public Health District: 2009-2013



	Aroostook	Central	Cumber.	Downeast	Midcoast	Penquis	Western	York	Maine
2009	13%	12%	11%	13%	14%	12%	13%	14%	13%
2011	12%	13%	11%	11%	15%	12%	14%	14%	13%
2013	14%	15%	14%		17%	13%	15%	16%	15%

Source: MIYHS

Mental Health and Substance Abuse Co-Occurrence

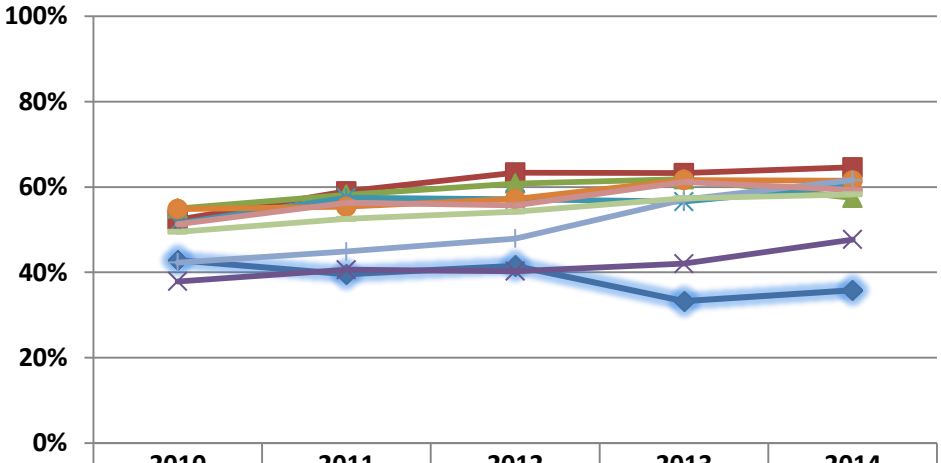
Indicator Description: CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT. This indicator reflects the proportion of treatment admissions for substance abuse where the individual also has a mental health diagnosis.

Why Indicator is Important: The link between mental health and substance abuse is well documented. In terms of treatment, it is important to know if one exists because the symptoms of each can affect the other.

Data Source(s): WITS, 2010-2014.

Summary: In 2014, 36 percent of individuals in Aroostook admitted for substance abuse treatment also had a mental health diagnosis; this was considerably lower the statewide rate (58%) and lowest among public health districts. Aroostook has consistently observed some of the lowest rates among public health districts for the past several years.

Figure 62. Percent of individuals by Public Health District admitted for substance abuse treatment that also had a mental health diagnosis: 2010-2014



	2010	2011	2012	2013	2014
Aroostook	43%	40%	42%	33%	36%
Central	52%	59%	63%	63%	65%
Cumberland	55%	58%	61%	62%	57%
Downeast	38%	41%	40%	42%	48%
Midcoast	52%	58%	57%	57%	60%
Penquis	55%	55%	57%	62%	61%
Western	42%	45%	48%	57%	62%
York	51%	56%	56%	61%	59%
Maine	49%	53%	54%	57%	58%

Source: WITS

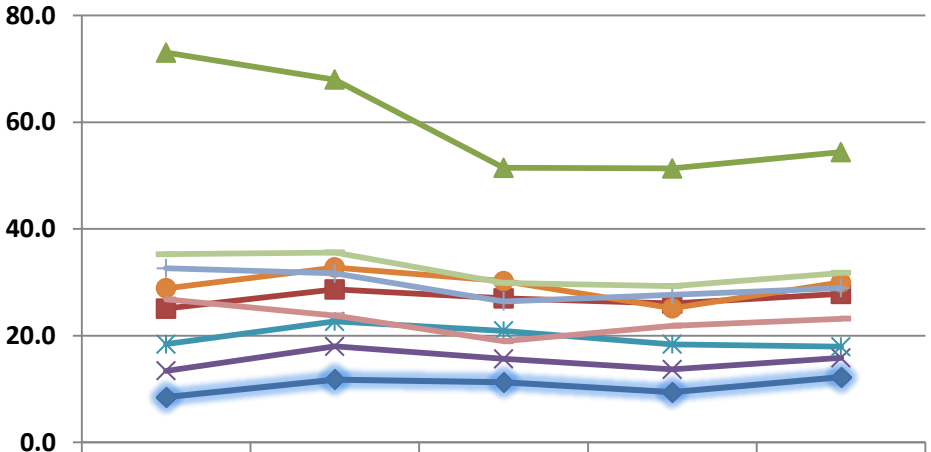
Indicator Description: INFORMATION CALLS FOR MENTAL HEALTH AND HUMAN SERVICES. 2-1-1 Maine is a telephone and internet service that provides information and referrals to health and human services. This indicator reflects the number of calls received by Maine 2-1-1 by the type of service requested.

Why Indicator is Important: The data collected from each call provides valuable information serving as a barometer of health and human service needs in the state.

Data Source(s): 2-1-1 Maine, 2010-2014

Summary: In 2014, Aroostook observed 12.2 Maine 2-1-1 referral calls related to mental health services per 10,000 residents; this was much lower than the statewide rate (31.7 calls per 10,000 residents) and lowest among public health districts. Aroostook's rates have remained relatively stable since 2010.

Figure 63. Number of Maine 2-1-1 referral calls related to mental health services per 10,000 residents, by public health districts: 2010-2014



	2010	2011	2012	2013	2014
Aroostook	8.5	11.8	11.3	9.4	12.2
Central	25.1	28.6	27.0	26.0	27.8
Cumberland	73.0	68.0	51.5	51.3	54.4
Downeast	13.4	18.0	15.6	13.7	15.8
Midcoast	18.4	22.7	20.9	18.4	17.9
Penquis	28.9	32.7	30.2	25.1	30.0
Western	32.6	31.6	26.4	27.6	28.9
York	26.8	23.8	18.9	21.9	23.2
Maine	35.2	35.6	29.9	29.3	31.7

Source: 211 Maine, 2010-2014

Treatment Admissions for Substance Abuse

Substance abuse treatment admissions are an indicator of how many people *receive treatment* for a substance abuse problem. These admissions can be voluntary, but they can also be court-ordered. Treatment admission data should not be used as an indicator of the magnitude of the problems related to substance abuse. Rather, treatment should been seen a major consequence stemming from substance use and one that requires many resources.

Mainers continue to seek out treatment for abuse involving a wide array of substances besides alcohol; in 2014 3,589 clients were admitted for alcohol as the primary substance. This was followed by synthetic opioids (2,663) and heroin (2,538).

In Aroostook, nearly half of primary treatment admissions were for alcohol and about one-quarter were for synthetic opioids. From 2013 to 2014, it appears that the proportions of primary and secondary treatment admissions related to alcohol have decreased while those related to synthetic opioids have increased. In 2014, among public health districts, Aroostook had the second highest rate of alcohol-related primary admissions per 10,000 residents, the highest rate of marijuana-related primary admissions per 10,000 residents, and the lowest rate of heroin/morphine-related primary admissions per 10,000 residents.

Treatment Admissions

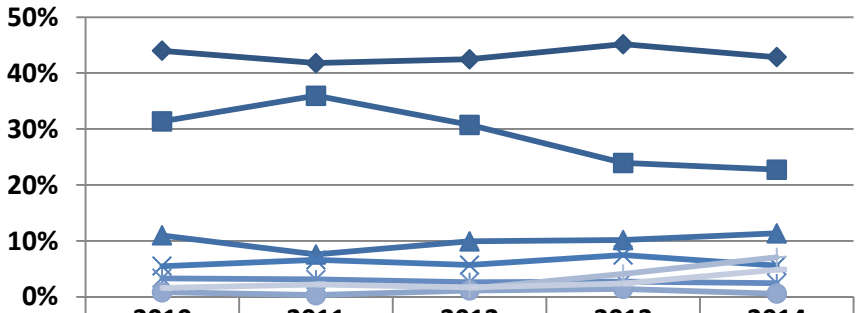
Indicator Description: PRIMARY TREATMENT ADMISSIONS. This measure reflects substance abuse treatment admissions by licensed substance abuse treatment agencies/providers. A "primary" substance is identified during the treatment admissions process based on use patterns (e.g., frequency, duration, quantity) and the risk(s) posed to the individual. The analysis excludes admissions for shelter/detoxification services.

Why Indicator is Important: The number of substance abuse treatment admissions is bound by both the need and the capacity for treatment. Treatment admissions data are not a good indicator of substance use, abuse or dependence, but provide an indication of service usage and the impact of substance use on the behavioral healthcare system.

Data Source(s): WITS, 2010-2014.

Summary: In 2014, 43 percent of all primary treatment admissions in Aroostook were related to alcohol, followed by synthetic opioids[8] (23%) and marijuana (11%). The majority of primary admissions for treatment in Aroostook have been related to alcohol since 2010. Primary admissions related to synthetic opioids in Aroostook have been steadily decreasing since 2011.

Figure 64. Primary drug admissions for in Aroostook, by drug type: 2010-2014



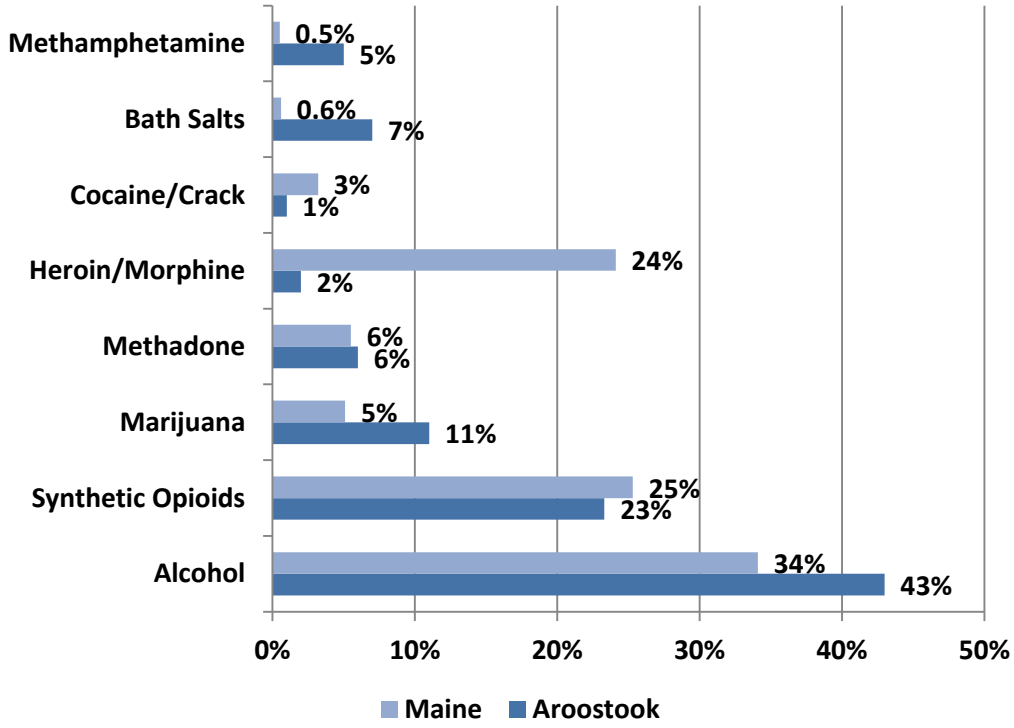
	2010	2011	2012	2013	2014
Alcohol	44%	42%	42%	45%	43%
Synthetic Opioids	31%	36%	31%	24%	23%
Marijuana	11%	8%	10%	10%	11%
Methadone	5%	7%	6%	7%	6%
Heroin/Morphine	3%	3%	3%	3%	2%
Cocaine/Crack	1%	0%	1%	1%	1%
Bath salts			1%	4%	7%
Methamphetamine	2%	2%	2%	2%	5%

Source: WITS

[8] "Synthetic opioids" excludes methadone and buprenorphine.

Summary: In 2014, the proportion of primary treatment admissions for alcohol in Aroostook was 9 percentage points higher than the statewide average (43% compared to 34%), while the rate for heroin was 22 percentage points lower than the state (2% compared to 24%). In addition, it is worth mentioning that in 2014 the proportions of primary admissions related to methamphetamine (5%) and bath salts (7%) were considerably higher than rates statewide.

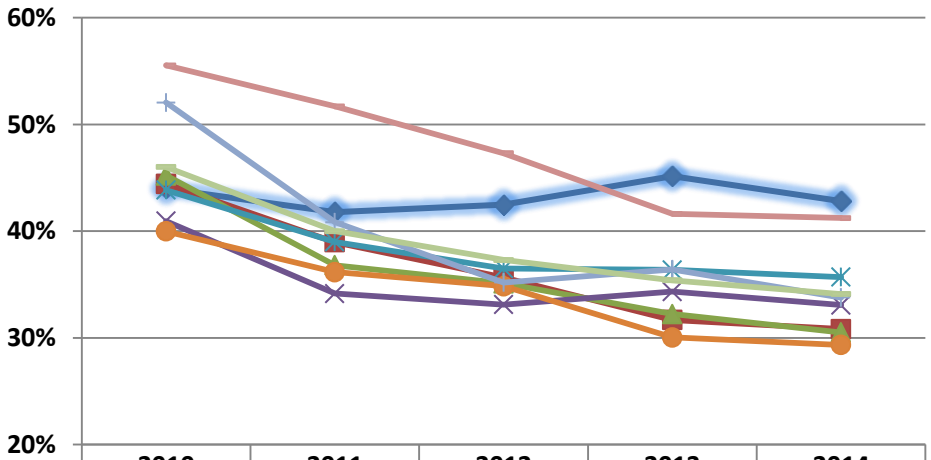
Figure 65. Primary treatment admissions in Aroostook: 2014



Source: WITS

Summary: In 2014, Aroostook had the highest rate among public health districts of primary treatment admissions due to alcohol (43%). For the past several years, Aroostook has observed some of the highest rates of primary admissions related to alcohol.

Figure 66. Primary admissions related to alcohol, by Public Health District: 2010-2014

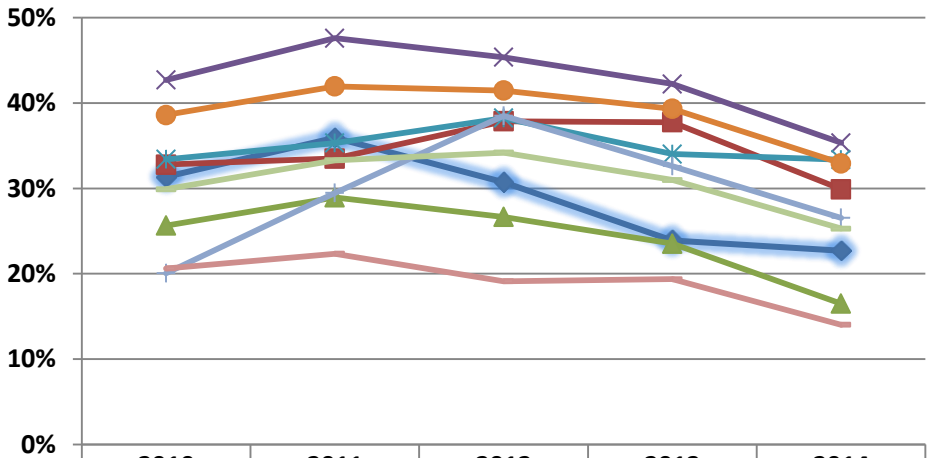


	2010	2011	2012	2013	2014
Aroostook	44%	42%	42%	45%	43%
Central	44%	39%	36%	32%	31%
Cumberland	45%	37%	35%	32%	31%
Downeast	41%	34%	33%	34%	33%
Midcoast	44%	39%	36%	36%	36%
Penquis	40%	36%	35%	30%	29%
Western	52%	41%	35%	36%	34%
York	56%	52%	47%	42%	41%
Maine	46%	40%	37%	35%	34%

Source: WITS

Summary: In 2014, Aroostook had the third lowest rate of primary treatment admissions related to synthetic opioids. The proportion of primary admissions related to synthetic opioids decreased by 13 percentage points since 2011 (from 36% to 23%).

Figure 67. Primary admissions related to synthetic opioids, by Public Health District: 2010-2014

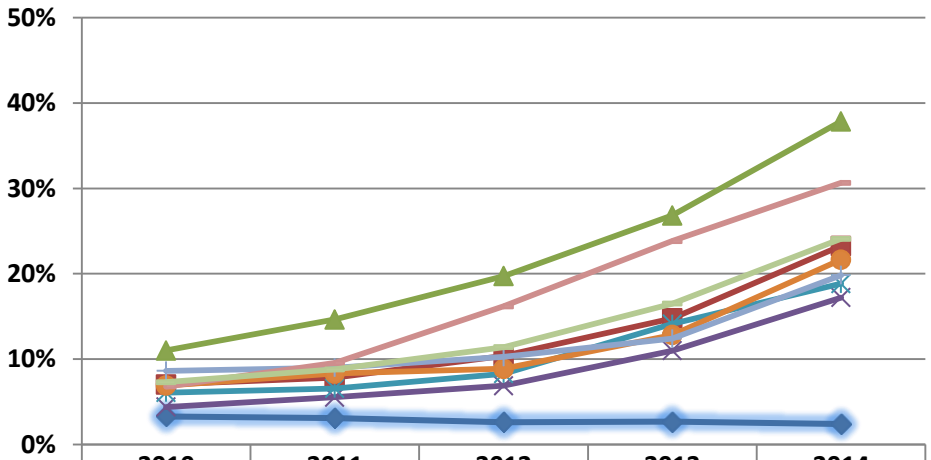


	2010	2011	2012	2013	2014
Aroostook	31%	36%	31%	24%	23%
Central	33%	34%	38%	38%	30%
Cumberland	26%	29%	27%	24%	17%
Downeast	43%	48%	45%	42%	35%
Midcoast	33%	35%	38%	34%	33%
Penquis	39%	42%	41%	39%	33%
Western	20%	29%	39%	33%	27%
York	21%	22%	19%	19%	14%
Maine	30%	33%	34%	31%	25%

Source: WITS

Summary: Aroostook is the only public health district to have not observed a steady increase in the proportion of primary admissions due to heroin. For the past several years, only two to three percent of primary admissions have been related to heroin.

Figure 68. Primary admissions related to heroin/morphine, by Public Health District: 2010-2014

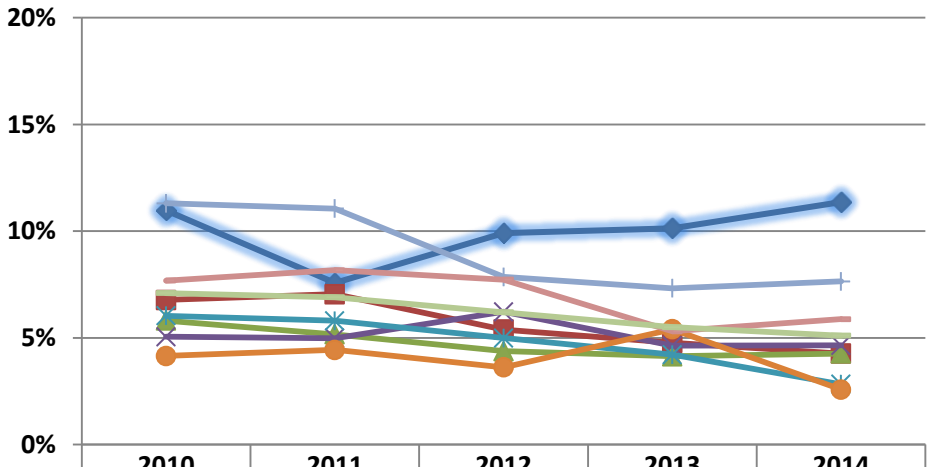


	2010	2011	2012	2013	2014
Aroostook	3%	3%	3%	3%	2%
Central	7%	8%	10%	15%	23%
Cumberland	11%	15%	20%	27%	38%
Downeast	4%	6%	7%	11%	17%
Midcoast	6%	7%	8%	14%	19%
Penquis	7%	8%	9%	13%	22%
Western	9%	9%	10%	12%	20%
York	7%	10%	16%	24%	31%
Maine	7%	9%	11%	17%	24%

Source: WITS

Summary: From 2012 to 2014, Aroostook observed the highest proportions of primary treatment admissions related to marijuana. Aroostook's rate increased from eight percent in 2011 to 11 percent in 2014; this was six percentage points higher than the 2014 statewide rate.

Figure 69. Primary admissions related to marijuana, by Public Health District and drug type: 2010-2014



	2010	2011	2012	2013	2014
Aroostook	11%	8%	10%	10%	11%
Central	7%	7%	5%	5%	4%
Cumberland	6%	5%	4%	4%	4%
Downeast	5%	5%	6%	5%	5%
Midcoast	6%	6%	5%	4%	3%
Penquis	4%	4%	4%	5%	3%
Western	11%	11%	8%	7%	8%
York	8%	8%	8%	5%	6%
Maine	7%	7%	6%	6%	5%

Source: WITS

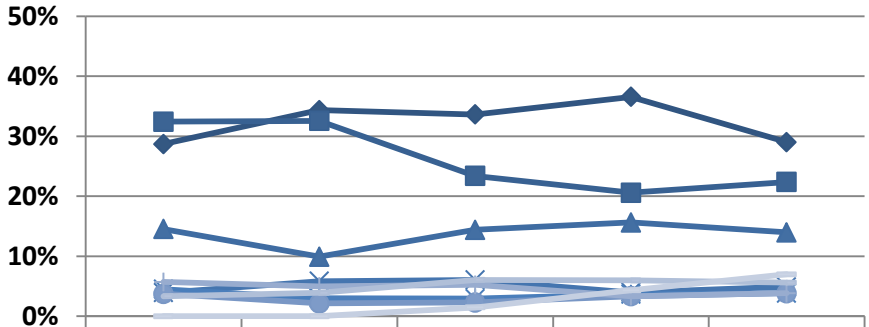
Indicator Description: SECONDARY TREATMENT ADMISSIONS. This measure reflects substance abuse treatment admissions by licensed substance abuse treatment agencies/providers. A "secondary" substance is identified during the admissions process as one used by the individual and for which treatment may be received, but it is not the primary substance for which treatment was sought. The analysis excludes admissions for shelter/detoxification services.

Why Indicator is Important: The number of substance abuse treatment admissions is bound by both the need and the capacity for treatment. Treatment admission data are not a good indicator of substance use, abuse or dependence, but provide an indication of service usage and the impact of substance use on the behavioral healthcare system.

Data Source(s): WITS, 2010-2014.

Summary: In 2014, 29 percent of secondary treatment admissions in Aroostook were for marijuana, followed by synthetic opioids (22%) and then alcohol (14%). While secondary admissions related to marijuana and alcohol have remained relatively stable over the past several years, it appears that secondary admissions related to synthetic opioids have been decreasing overall. In addition, it is worth mentioning that the proportion of secondary admissions related to bath salts increased from one percent in 2012 to seven percent in 2014.

Figure 70. Secondary treatment admissions in Aroostook: 2010-2014

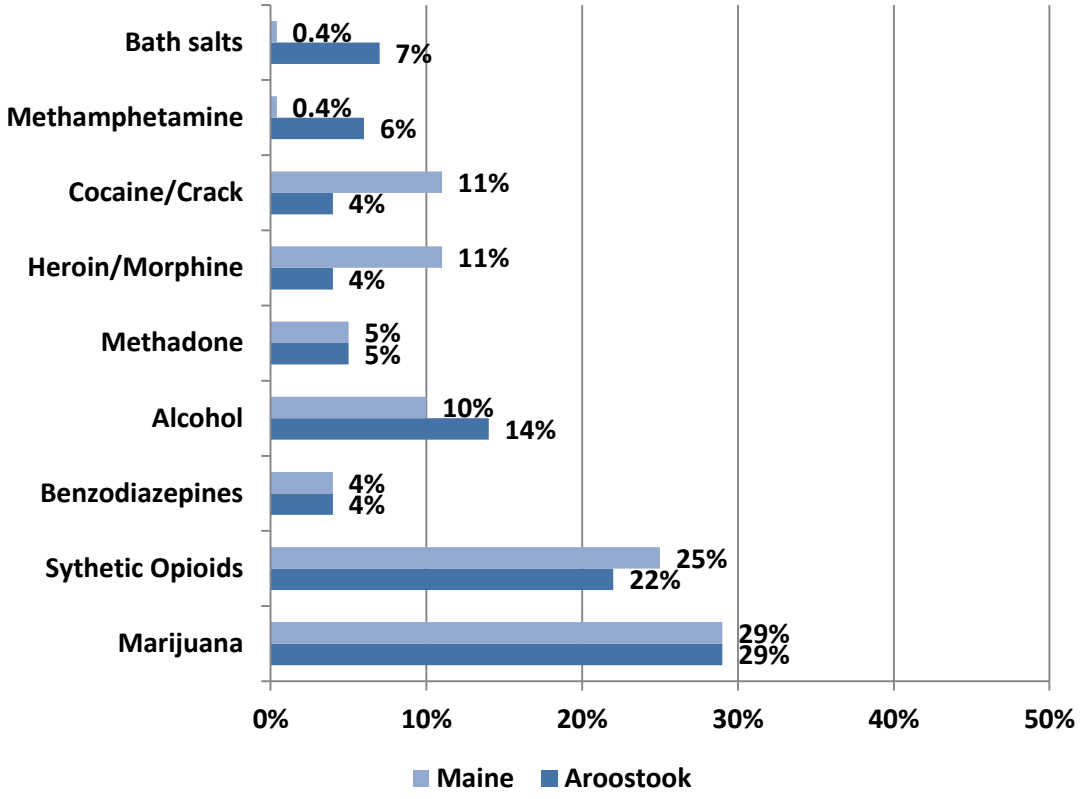


	2010	2011	2012	2013	2014
Marijuana	29%	34%	34%	37%	29%
Sythetic Opioids	32%	33%	23%	21%	22%
Alcohol	15%	10%	14%	16%	14%
Methadone	4%	6%	6%	4%	5%
Heroin/Morphine	5%	3%	3%	4%	4%
Cocaine/Crack	4%	2%	2%	3%	4%
Benzodiazepines	6%	5%	5%	3%	4%
Methamphetamine	3%	4%	6%	6%	6%
Bath salts	0%	0%	1%	4%	7%

Source: WITS

Summary: In 2014, Aroostook had a greater proportion of secondary admissions related to alcohol (16%), bath salts (7%), and methamphetamine (16%) compared to secondary treatment admissions statewide. While Aroostook's proportions of secondary treatment admissions related to marijuana and synthetic opioids were on par with those of the state, it observed much lower rates regarding heroin/morphine and cocaine/crack.

Figure 71. Secondary treatment admissions in Aroostook, by drug type: 2014



Source: WITS

Appendix: Data Sources

This report includes data that was gathered from a number of data sources. A detailed description of each source is provided below, consisting of information about the data included in each source, and retrieval or contact information. The report includes data that were available through May 2015.

There are multiple purposes for this report. One is to provide a snapshot of the most recent data regarding substance abuse, while another is to examine trends over time. Therefore, each indicator may have multiple sources of data that are included. While each indicator provides a unique and important perspective on drug use in Maine, none should individually be interpreted as providing a full picture of drug trends in Maine. In particular, the percentages and figures from one data source do not always align with the data and percentages from a similar source. Older data are often included in order to examine an indicator among a specific population or to find trends over time. When discussing rates of prevalence, however, the user should rely upon the most recent data source available.

Description of Data Sources

Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national survey administered on an ongoing basis by the National Centers for Disease Control and Prevention (CDC) to adults in all 50 states and several districts and territories. The instrument collects data on adult risk behaviors, including alcohol abuse. BRFSS defines heavy drinking as adult men having more than two drinks per day and adult women having more than one drink per day, and binge drinking as males having five or more drinks on one occasion and females having four or more drinks on one occasion. The most recent data available are from 2012. **Due to methodological changes in weighting and sampling, data prior to 2011 cannot be trended with more current data.** In addition, in some cases years were combined to yield more stable estimates. Contact: Melissa Damren, Maine BRFSS Coordinator; melissa.damren@maine.gov; (207) 287-1420.

Maine Department of Public Safety (DPS), Uniform Crime Reports (UCR). UCR data include drug and alcohol arrests. Drug arrests include sale and manufacturing as well as possession of illegal substances. Liquor arrests include all liquor law violations. OUI arrests are arrests for operating a motor vehicle under the influence of a controlled substance. DPS data are now available from 2013. Arrest data may reflect differences in resources or focus of law enforcement efforts, so may not be directly comparable from year to year.
Retrieval: http://www.maine.gov/dps/cim/crime_in_maine/cim.htm

Maine Department of Public Safety (DPS), Liquor Licensing and Compliance. DPS issues and renews licenses for the manufacture, importation, storage, transportation and sale of all liquor and administers those laws relating to licensing and the collection of taxes on malt liquor and wine. DPS maintains a list of all active licenses that can be accessed online.

Retrieval: http://www.maine.gov/dps/liqr/active_licenses.htm

Maine Department of Public Safety (DPS), Bureau of Highway Safety (BHS), Maine Department of Transportation (MDOT). The Bureau of Highway Safety is responsible for tracking all fatalities that occur on Maine's highways and reporting this information through the Fatal Analysis Reporting System (FARS). The data represented provides information on highway crashes and fatalities. Much of this information is gathered from our FARS system, which records data on fatal crashes in Maine for input into a larger national record-keeping system of statistical data. FARS data is also used by BHS and the Maine State Police to analyze enforcement priorities and schedules. Impaired driving is one of the most serious traffic risks facing the nation, killing thousands every year. Contact: Duane Brunell, Safety Performance Analysis Manager; duane.brunell@maine.gov; (207) 624-3278.

Maine Drug Enforcement Agency (MDEA). The MDEA, through its eight regional multi-jurisdictional task forces, is the lead state agency in confronting drug trafficking crime. This indicator differs from the Uniform Crime Report drug-related arrest data in that it only tracks MDEA efforts and does not encompass all activity within Maine law enforcement agencies. The data included in this report represents those arrested for a drug offense but does not indicate what other drug(s) may have been seized. For example, a person may be arrested for the sale of cocaine but also be in possession of oxycodone and marijuana. It is important to note that arrests and multi-jurisdictional drug enforcement are resource-dependent; such funds fluctuate from year to year, and must be reallocated to combat highest priority threats. Contact: Roy E. McKinney, Director; roy.e.mckinney@maine.gov; (207) 626-3852.

Maine Emergency Medical Services (EMS). Maine EMS is a bureau within the Maine Department of Public Safety (DPS) and is responsible for the coordination and integration of all state activities concerning Emergency Medical Services and the overall planning, evaluation, coordination, facilitation and regulation of EMS systems. EMS collects data statewide from the 272 licensed ambulance and non-transporting services. It is mandated that services submit an electronic patient care report to Maine EMS within one business day of patient contact. Data are compiled upon request. Contact: Jon Powers, Maine Emergency Medical Services; jon.powers@maine.gov; (207) 626-3860.

Maine Integrated Youth Health Survey (MIYHS). The MIYHS is a statewide survey administered biennially through a collaborative partnership by the Maine Office of Substance Abuse (OSA) the Maine Center for Disease Control and Prevention and the Maine department of Education to students in grades 5 through 12. The survey collects information on student substance use, risk factors related to substance use, as well as consequences, perceptions and social risk factors related to substances, and collects information on many other health factors. As of the date of this report, the most recent data available are from 2013. Due to changes in the survey administration and structure, the new survey data cannot be trended with the Maine Youth Drug and Alcohol Survey (MYDAUS). In addition, **due to a low response rate, the Downeast public health district does not have estimates for 2013**. Contact: Stephen Corral, Substance

Abuse Program Specialist, Office of Substance Abuse, stephen.corral@maine.gov; (207) 287-2964.

Maine Health Data Organization (MHDO). MHDO data includes all inpatient admissions to all hospitals in Maine for calendar years 2010 and 2011. Data categories created by the authors include alcohol, opioids, illegal drugs, and pharmaceuticals. All drug categories include intoxication, abuse, dependence, and poisoning cases related to the drug. The opiate category includes methadone, heroin, and opiates. The illegal drug category includes crack/cocaine, cannabis, and hallucinogens. The pharmaceuticals category includes all other non-opioid medications (including stimulants and depressants). Contact: Maine Health Data Organization (MHDO), lisa.parker@maine.gov; (207) 287-3225.

Marci Sorg, Margaret Chase Smith Policy Center at University of Maine, Office of the Chief Medical Examiner. The Maine Office of the Chief Medical Examiner maintains records of all deaths associated with drug overdose. Drug categories include methadone, cocaine, benzodiazepines, oxycodone and heroin/morphine. The death data are compiled on an annual basis and must be finalized prior to release and so are not available to track changes that may occur over shorter time frames. Contact: Dr. Marcella Sorg, Director, Rural Drug & Alcohol Research Program, Margaret Chase Smith Policy Center, University of Maine; marcella_sorg@umit.maine.edu; (207) 581-2596.

National Survey on Substance Use and Health (NSDUH). The NSDUH is a national survey administered annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) to youth grades 6 through 12 and adults ages 18 and up. The instrument collects information on substance use and health at the national, regional and state levels. The advantage of NSDUH is that it allows comparisons to be made across the lifespan (that is, ages 12 and up). However, NSDUH is not as current as other data sources; as of this report, data at the substate level are available from 2008-2010. Older data are included for trending and comparative purposes. NSDUH defines Illicit Drugs as marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used non-medically; Binge Alcohol Use as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days; Dependence or abuse based on definitions found in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); and Serious Mental Illness (SMI) as a diagnosable mental, behavioral, or emotional disorder that met the criteria found in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and resulted in functional impairment that substantially interfered with or limited one or more major life activities. Retrieval: https://nsduhweb.rti.org/

Northern New England Poison Center (NNEPC). The Northern New England Poison Center provides services to Maine, New Hampshire, and Vermont. A poisoning case represents a single individual's contact with a potentially toxic substance. Intentional poisoning includes those related to substance abuse, suicide and misuse. Data include the number of confirmed cases where exposures are judged to be substance abuse-related (i.e., an individual's attempt to get

high). NNEPC collects detailed data on specific substances involved in poisonings, including the categories of stimulants/street drugs, alcohol, opioids, asthma/cold and cough, benzodiazepines, antidepressants, and pharmaceuticals, as well as other substances. The category of stimulants/street drugs includes marijuana and other cannabis, amphetamine and amphetamine-like substances, cocaine (salt and crack), amphetamine/dextroamphetamine, caffeine tablets/capsules, ecstasy, methamphetamine, GHB, and other/unknown stimulants/street drugs. The category alcohol includes alcohol-containing products such as mouthwash. The opioid category includes Oxycodone, Hydrocodone, buprenorphine, methadone, tramadol, morphine, propoxyphene, codeine, hydromorphone, stomach opioids, Meperidine (Demerol), heroin, Fentanyl, and other/unknown opioids. The asthma/cold and cough category includes eye, ear, nose, and throat medications. Data available from the poison center are reported on a continual daily basis and are included through December 2013. These data are only reflective of cases in which the Poison Center was contacted. Contact: Karen Simone, Director, Northern New England Poison Center; simonk@mmc.org; (207) 662-7221.

Office of Child and Family Services (OCFS), Maine Automated Child Welfare Information System (MACWIS). The Office of Child and Family Services (OCFS) supports Maine's children and their families by providing Children's Behavioral Health, Child Welfare, Early Childhood, and Community services. The Maine Child Welfare Information System (MACWIS) serves as the single repository for all Maine child welfare information to assist Office of Child and Family Services (OCFS) workers in the recording, tracking, and processing of child welfare functions. MACWIS is the single repository for all electronic child welfare information. It actively manages 850,000 identified persons and 28,525 resources in the system; lori.geiger@maine.gov; (207)-624-7911.

Prescription Monitoring Program (PMP). PMP maintains a database of all transactions for class C-II through C-IV drugs dispensed in the state of Maine. Drug categories used in this report include narcotics, tranquilizers, stimulants, and other prescriptions. Other prescriptions include those drugs that are not classified as narcotics, tranquillizers or stimulants, including products such as endocrine and metabolic drugs, analgesics and anesthetics, gastrointestinal agents, and nutritional products. The counts included in this report represent the quantity dispensed through prescriptions filled between 2009 and 2013. Contact: John Lipovsky, PMP Coordinator, Substance Abuse and Mental Health Services; john.lipovsky@maine.gov; (207) 287-3363.

WITS Substance Abuse Treatment Data System (WITS). WITS is a statewide database that includes information about clients admitted to treatment in SAMHS-funded facilities. Analyses in this report are based on clients' reported primary, secondary and tertiary drug(s) of choice as well as other demographic and background information that is collected at intake. Drug categories included in this report are alcohol, marijuana, cocaine, heroin, synthetic opiates, methadone/buprenorphine and benzodiazepines. Contact: Johanna Buzzell, Substance Abuse and Mental Health Services; johanna.buzzell@maine.gov; (207) 287-6337.

U.S. Census Bureau. The U.S. Census provides summary profiles showing frequently requested data items from various Census Bureau programs. Profiles are available for all states and

counties, and for cities and towns with more than 25,000 people. Data are updated no less than annually. Retrieval for Maine census data: http://quickfacts.census.gov/qfd/states/23000.html